DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

PART 3 (Pages 1-909)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

FRIDAY, FEBRUARY 20, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Quentin Burdick presiding.

Present: Senator Burdick.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES ADMINISTRATION

STATEMENT OF DR. ROBERT GRAHAM, ACTING ADMINISTRATOR

ACCOMPANIED BY:
- ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET
- DR. JAMES A. WALSH, ASSOCIATE ADMINISTRATOR FOR OPERATIONS AND MANAGEMENT
- DR. FLORENCE B. FIORI, DIRECTOR, BUREAU OF HEALTH FACILITIES
- THOMAS D. HATCH, ACTING DIRECTOR, BUREAU OF HEALTH PROFESSIONS
- DR. COLIN C. RORRIE, JR., DIRECTOR, BUREAU OF HEALTH PLANNING
- DR. CLAY E. SIMPSON, ASSOCIATE ADMINISTRATOR FOR HEALTH RESOURCES OPPORTUNITY PROGRAMS

SUBCOMMITTEE PROCEDURE

Senator BURDICK. Good morning.

Today we continue our hearings with testimony on the budget request for the Health Resources Administration in the Department of Health and Human Services.

The programs of HRA are designed to improve the efficient disposition of health facilities and increase the supply of health professionals in areas where they are needed.

Here to testify for HRA is Dr. Robert Graham, the Acting Administrator.

Dr. Graham, I welcome you. Please introduce your colleagues. Please proceed with your overview presentation as you wish.

Dr. GRAHAM. Mr. Chairman, thank you very much. I am happy to be here this morning.

PREPARED STATEMENT

I do have a prepared statement which has been supplied to you and I ask that it be submitted for the record.

Senator BURDICK. Without objection it will be included in total.

[The statement follows:]

STATEMENT OF DR. ROBERT GRAHAM

I am pleased to appear before the Committee today to discuss the mission and the accomplishments of the Health Resources Administration. The Agency administers the National Health Planning and Resources Development Act, the Health Professions Educational Assistance Act and the Nurse Training Act, both presently maintained under the Continuing Resolution, for FY 1981, P.L. 96-536.

Health Planning

In October 1979, the health planning legislation was extended for an additional three years and amended to alter the functioning of the program. Major changes in the legislation included: (1) changing the designation and planning cycles so that health planning agencies operate on a three-year rather than an annual cycle; (2) requiring coordination of State Health Plans with other planning, particularly in the areas of mental health, drug abuse, and alcoholism; (3) strengthening the role of the Governors; (4) revising the certificate-of-need program to exempt projects of certain large health maintenance organizations from review; and (5) highlighting the role of competition in the allocation of health services.

-Local Agencies and State Planning Agencies

Since the passage of the planning act amendments, the Health Systems Agencies and the State planning agencies have been moving to full designation, meaning that they are assuming the full range of functions required of them by the legislation. During this time their major focus has turned from establishing themselves, to implementing the objectives contained in their Health Systems Plans and State Plans. These plans which have been developed through the planning program are directed at accomplishing goals and objectives for health care which are keyed to State and local needs, for example, improved access, and attaining delivery system efficiencies.

-Improvements made by the Planning Program

The past five years have been devoted toward the task of establishing a national planning network comprised of thousands of professionals and volunteers. In this context, a major accomplishment has been the involvement of an extensive number of public, professional, industry, and labor representatives in jointly working towards accomplishing health care goals and objectives in a collaborative fashion.

Health Facilities:

The Health Resources Administration's facilities program directs its resources toward: 1) assisting National and State organizations in the development of efficient health facilities planning, capital formation, and the reduction of unnecessary beds and inefficient facility utilization; 2) assisting facilities receiving Federal funding to comply with requirements to provide a reasonable level of uncompensated care to persons unable to pay; 3) administering a program designed to promote energy conservation and cost savings by health facilities; 4) monitoring more than $3 billion in outstanding health facility loans and guarantees in order to minimize Federal default liability; 5) monitoring health facility construction grants, recovering Federal funds where required.

-Improvements made by the facilities program

Since its establishment in 1978 the health facilities program has in the areas of:

Assurances monitoring: worked with more than 5,000 hospitals to assist these hospitals in providing an estimated $500 million in free care to the medically underserved in FY 1982.

Facilities Loan Monitoring: developed a loan early warning system which has kept loan defaults at a minimum, and administered a recovery program which we estimate will return $20 million to the Treasury by the end of fiscal 1982.

Energy Conservation: maintains the only Federal entity for hospital contingency planning during an energy crisis; and administers a hospital sector energy conservation program with the potential of saving more than a billion dollars a year in avoided energy costs.

Health Professions

The Health Resources Administration's Health Professions Educational Assistance program is designed to address five major objectives:

1) remove incentives for unwarranted growth in the aggregate supply of health professions;
2) promote a sufficient supply of primary care professionals; relative to other types of specialists;
3) specialized programs to help assure the availability of health professionals in underserved areas;
4) increase minority participation in the health professions; and
5) promote national health care priorities through special projects.

-Unwarranted growth in aggregate supply of Professionals

Programs in earlier years addressed the need to increase the number of trained health professionals by providing fiscal incentives through Health Professions and Nursing Capitation grants. Primarily as a result of increased educational capacity developed during these years, existing indications and the recent report of the Graduate Medical Education National Advisory Committee point to a possible oversupply of physicians in some specialities by 1990.

Consistent with the objective of removing incentives for unwarranted growth in aggregate supply, we have phased down programs designed merely to increase the numbers of health professionals such as capitation grants, construction grants, and start-up assistance.

-Sufficient supply of primary care professionals:

Although recent studies show the need for a curtailment of generic Federal programs designed to increase the numbers of all health professionals the same studies point to the need for continued federal support of programs directed at increasing the numbers of specific health practitioners. The Health Resources Administration addresses this objective through the continued support of programs such as family medicine residencies and training, and general internal medicine and pediatrics residencies and training.

-Availability of health professionals in underserved areas:

A major HRA initiative directed at this objective is the Area Health Education Center (AHEC) program. The AHEC program addresses problems of geographic maldistribution and over-specialization of health professionals by fostering changes in the pattern of education and the educational environment. Through this program, funds are provided to medically underserved areas to improve the coordination and use of existing resources within these areas.

HRA's nurse practitioner program also contributes toward achieving the objective of providing additional health professionals for underserved areas since the majority of these practitioners will locate in medically underserved areas.

-Increase minority participation in health professions:

Consistent with this objective, HRA's disadvantaged assistance program helps persons from minority and disadvantaged backgrounds qualify for entry into professional schools. Emphasis is placed on involving the health professions schools in coordinated efforts to enlarge the minority applicant pool and to foster among these schools a commitment to increasing minority enrollments.

-Special projects for legislatively authorized health care priorities:

These programs are directed toward the promotion of national health care priorities through the development and implementation of targeted special projects. Health professions special projects focus on national priority areas such as public health and health administration training with special focus on community health planning, environmental and occupational health, nutrition and health education counseling.

In the area of nursing, areas of national priority which are addressed through HRA special projects, include (1) to improve the distribution of nurses by geographic area focusing on areas with low-income populations; (2) to increase nursing education opportunities for individuals from disadvantaged minority backgrounds; (3) to develop innovative nursing techniques to help meet the needs of high-risk target groups, especially the elderly, children and pregnant women, and emphasizing primary care and prevention; and (4) to provide training to enhance clinical skills, including continuing education opportunities and advanced nurse training concentrating on primary care and needs of the above high-risk target groups.

Thank you for the opportunity to appear before you today, and I will be pleased to answer any questions you may have.

Health Resources Administration
Regulatory Activities

The Health Resources Administration is an Agency that provides financial assistance and guidance to public and private entities in such categories as health planning, health care facilities and resources development, and health professions education. Activities such as the Certificate of Need (Sec. 1527, T. XV, PHS Act) and the Limitation on Federal Participation for Capital Expenditures (Sec. 1122, T. XI, Soc. Ser. Act) have a regulatory element.

Under CON, State planning agencies are required to approve or disapprove applications from health care facilities for captial expenditures, the acquisition of major medical equipment, and new or revised institutional health services when exceeding preset limits, usually $150,000.

Under Section 1122 designated agencies conduct reviews of proposed capital expenditures for health care facilities if they exceed $100,000, change bed capacity or significantly effect a clinically related service. States are encouraged to operate both CON and Sec. 1122 programs as Sec. 1122 covers certain capital expenditures not in the CON requirements.

The National Guidelines for Health Planning (Sec. 1501, T. XV, PHS Act) are designed to provide guidance and technical assistance to help local and State health planning agencies in the development of plans. Cost savings or improvements in their health systems may result if the locality choses to include the attainment of a specific national goal as an objective in their health systems plan.

The Health Planning Act (Sec. 15.13(e), T. XV, PHS Act) requires Health Systems Agencies to review and approve or disapprove certain proposed uses of Federal health funds. The activity is designed to ensure that the Public Health Service funds subject to review are spent in a manner consistent with the needs of the Nation's communities as established in State and local health plans.

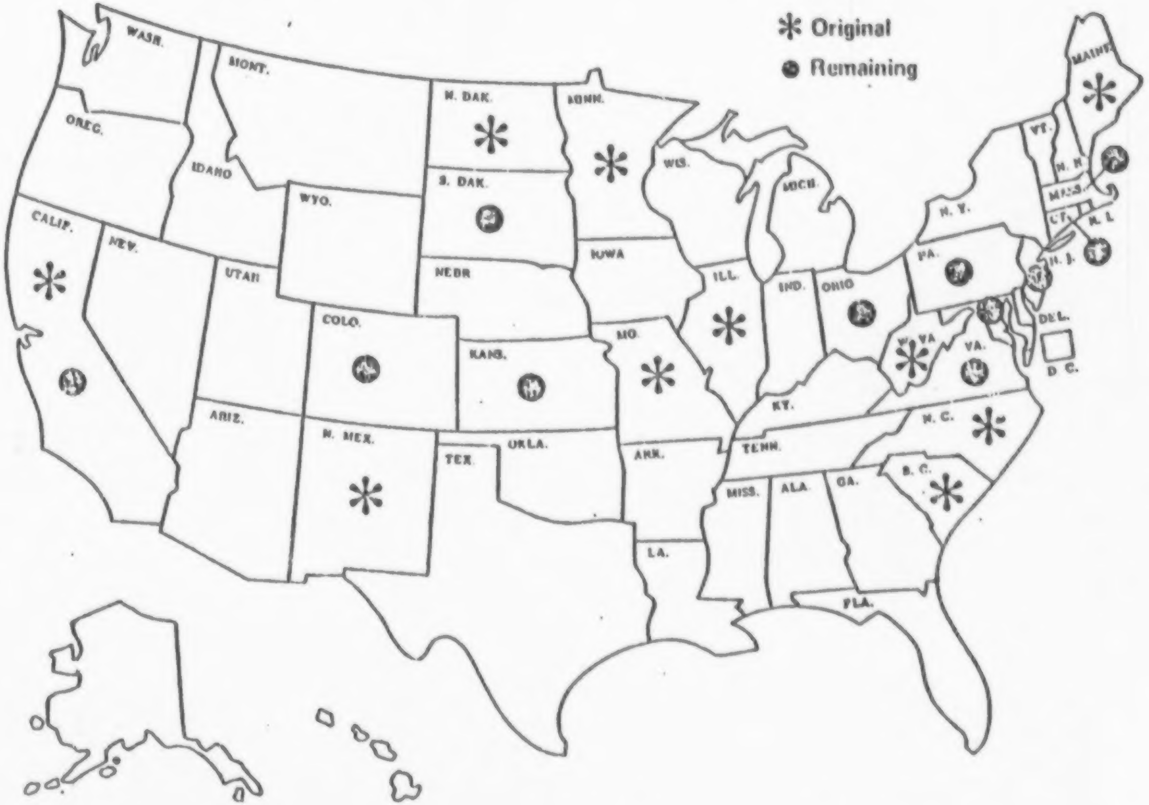
Under the Assurances Monitoring program (Sec. 1627, T. XVI, PHS Act) institutions which received financial support for health facility construction are required to provide a reasonable volume of uncompensated care to persons unable to pay. These facilities are required to develop a plan for the allocation of these services. The facilities are required to report once every three years on their provision of uncompensated services, unless they do not meet their annual level, in which case they must file a lower level of compliance report annually.

Other programs such as Appropriateness Review (Sec. 1523(a)(6), T. XV, PHS Act) provides for the analysis and review of existing health care services in terms of quality, cost, access and accessability to determine whether or not change is needed in the delivery of given services to improve the health care community. Foreign Medical Graduates and Waiver Board (Sec. 404, P.L. 96-538) requires that such graduates meet certain proficiency standards, residency requirements, and other special criteria before they are eligible to receive training at a U.S. medical school. The Shortage Area Designation law (Sec. 332, P.L. 94-484) requires the Agency to designate health professions shortage areas, including geographic areas, population groups and facilities. Criteria for this designation are required to be established by regulation and will directly impact upon the amount of Federal assistance a particular locality may receive.

The following table provides the expenditure data for 1980 and 1981. We will be glad to furnish any additional data you may require.

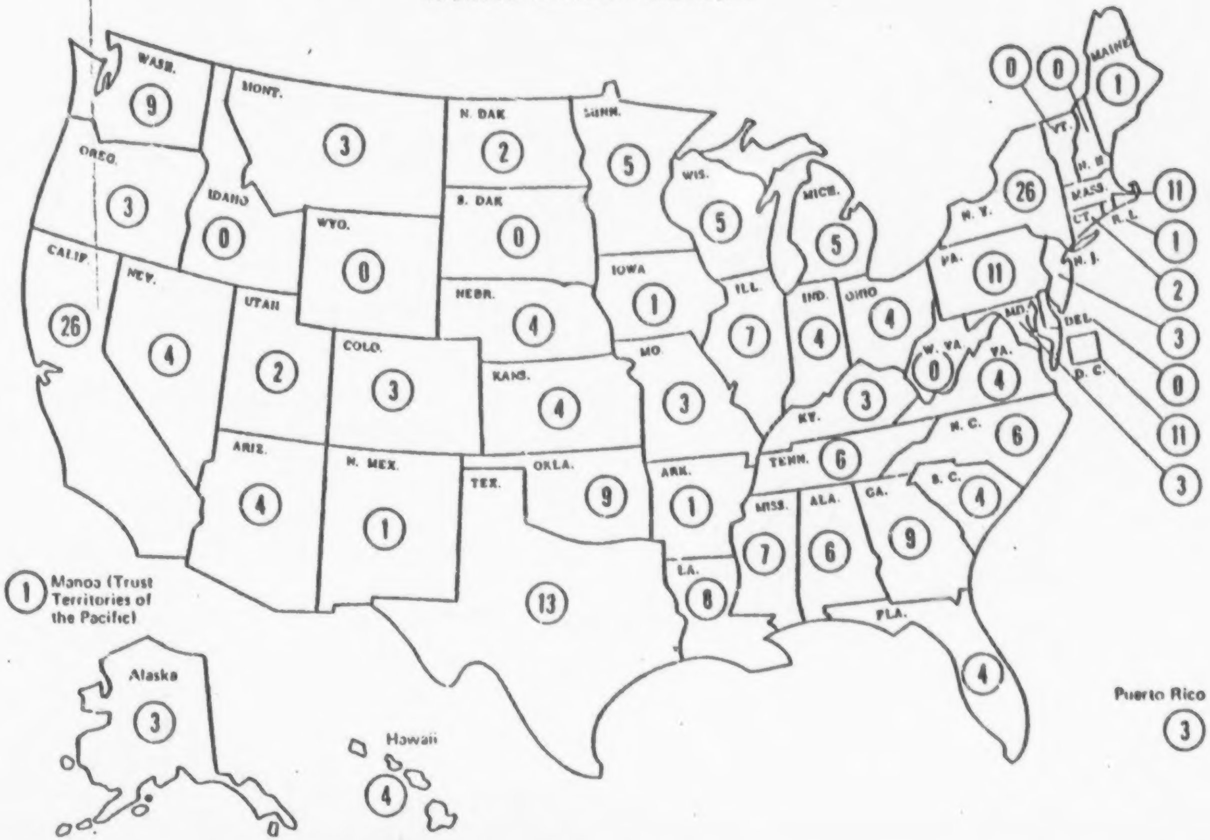
Fiscal Year	FTP Staff	Development	Promulgation	Enforcement	Total
1980	71	$473,300	$366,500	$1,763,000	$2,566,800
1981	60	$362,100	$327,200	$1,757,800	$2,447,000

AREA HEALTH EDUCATION CENTERS

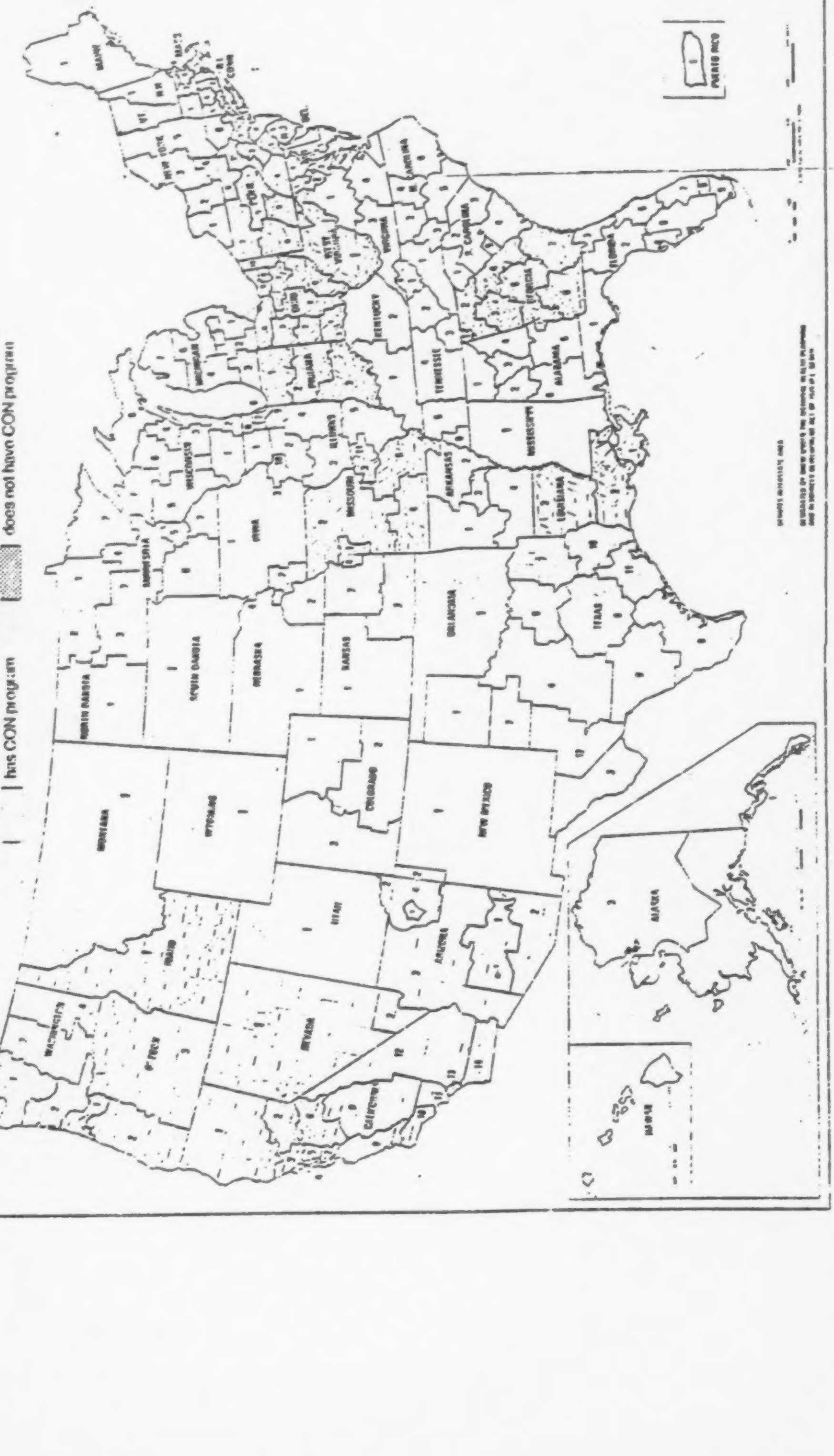

✻ Original
● Remaining
WASH.
MONT.
N. DAK.
MINN.
OREG.
IDAHO
S. DAK.
WIS.
MICH.
N. Y.
VT.
N. H.
MAINE
MASS.
CT.
R. I.
WYO.
CALIF.
NEV.
UTAH
NEBR
IOWA
ILL.
IND.
OHIO
PA.
N. J.
DEL.
COLO.
KANS.
MO.
W. VA.
VA.
D. C.
KY.
ARIZ.
N. MEX.
TEX.
OKLA.
ARK.
TENN.
N. C.
S. C.
MISS.
ALA.
GA.
LA.
FLA.

SHCOG / HCOP GRANTS 1972-1980

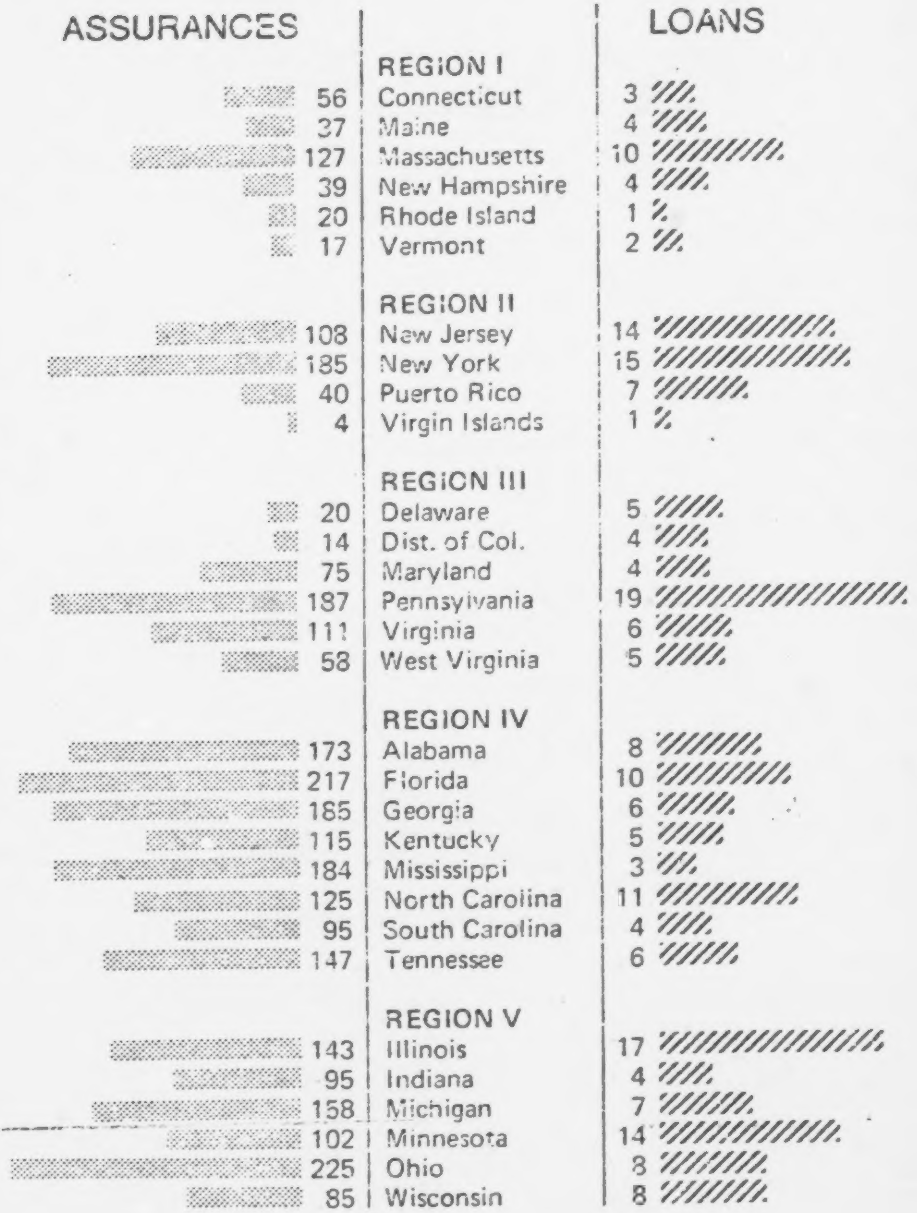
46 States & Territories 258 Projects


WASH. 9
OREG. 3
CALIF. 26
IDAHO 0
NEV. 4
MONT. 3
WYO. 0
UTAH 2
COLO. 3
ARIZ. 4
N. MEX. 1
N. DAK 2
S. DAK 0
NEBR. 4
KANS. 4
OKLA. 9
TEX. 13
MINN. 5
IOWA 1
MO. 3
ARK. 1
LA. 8
WIS. 5
ILL. 7
MICH. 5
IND. 4
OHIO 4
KY. 3
TENN. 6
MISS. 7
ALA. 6
GA. 9
FLA. 4
S. C. 4
N. C. 6
VA. 4
W. VA. 0
PA. 11
N. Y. 26
MAINE 1
VT. 0
N. H. 0
MASS. 11
R. I. 1
CT. 2
N. J. 3
DEL. 0
MD. 11
D. C. 3
Alaska 3
Hawaii 4
Puerto Rico 3
1 Manoa (Trust Territories of the Pacific)

STATES WITH CONFORMING CON PROGRAMS


has CON program
▨ does not have CON program
MAINE
N.H.
MASS.
VT.
R.I.
CONN.
NEW YORK
PENN.
DEL.
WEST VIRGINIA
VIRGINIA
N. CAROLINA
S. CAROLINA
GEORGIA
FLORIDA
OHIO
KENTUCKY
TENNESSEE
ALABAMA
MISSISSIPPI
INDIANA
MICHIGAN
ILLINOIS
WISCONSIN
MISSOURI
ARKANSAS
LOUISIANA
IOWA
MINNESOTA
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MONTANA
WYOMING
COLORADO
NEW MEXICO
UTAH
ARIZONA
IDAHO
WASHINGTON
OREGON
NEVADA
CALIFORNIA
ALASKA
HAWAII
PUERTO RICO

ASSURANCES AND LOANS MONITORED



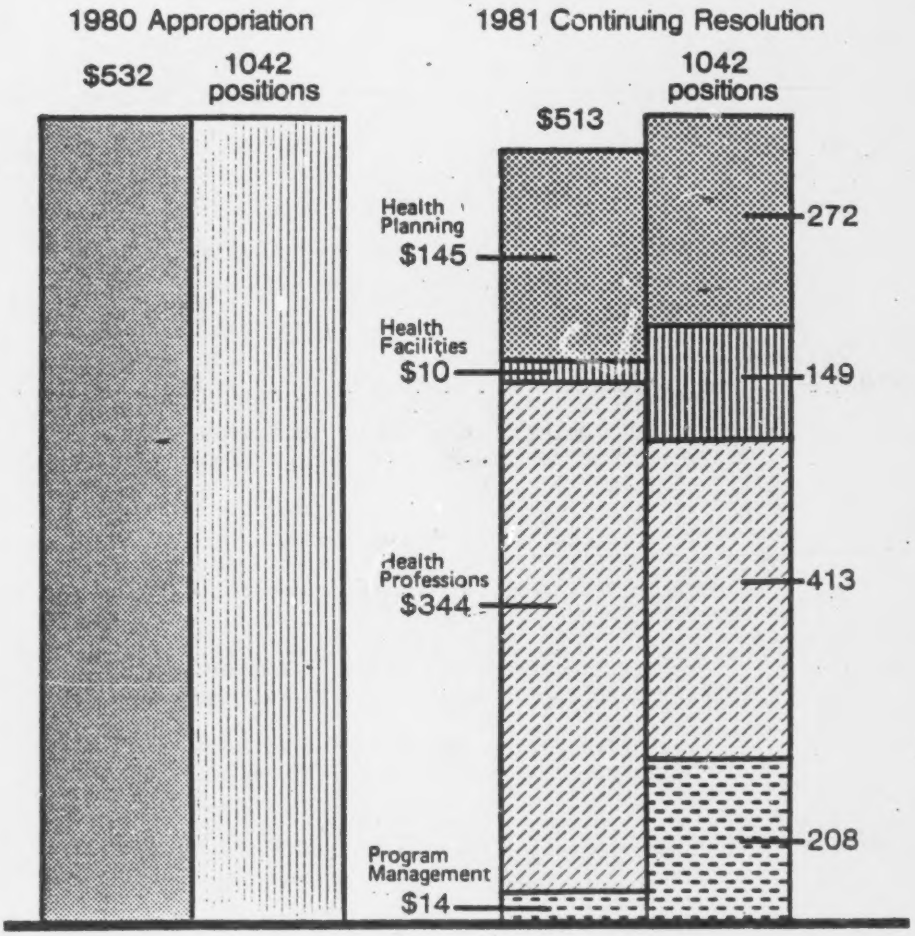
ASSURANCES		LOANS
	REGION I	
56	Connecticut	3
37	Maine	4
127	Massachusetts	10
39	New Hampshire	4
20	Rhode Island	1
17	Vermont	2
	REGION II	
108	New Jersey	14
185	New York	15
40	Puerto Rico	7
4	Virgin Islands	1
	REGION III	
20	Delaware	5
14	Dist. of Col.	4
75	Maryland	4
187	Pennsylvania	19
111	Virginia	6
58	West Virginia	5
	REGION IV	
173	Alabama	8
217	Florida	10
185	Georgia	6
115	Kentucky	5
184	Mississippi	3
125	North Carolina	11
95	South Carolina	4
147	Tennessee	6
	REGION V	
143	Illinois	17
95	Indiana	4
158	Michigan	7
102	Minnesota	14
225	Ohio	8
85	Wisconsin	8

ASSURANCES AND LOANS MONITORED
(continued)

ASSURANCES		LOANS
	REGION VI	
97	Arkansas	15
123	Louisiana	4
46	New Mexico	4
127	Oklahoma	6
259	Texas	47
	REGION VII	
87	Iowa	2
73	Kansas	3
122	Missouri	6
52	Nebraska	6
	REGION VIII	
66	Colorado	4
42	Montana	5
37	North Dakota	7
48	South Dakota	9
26	Utah	0
22	Wyoming	1
	REGION IX	
—	American Samoa	0
41	Arizona	2
195	California	12
6	Guam	0
27	Hawaii	1
21	Nevada	1
1	Trust Territory	0
	REGION X	
10	Alaska	2
34	Idaho	3
62	Oregon	4
55	Washington	7

HEALTH RESOURCES ADMINISTRATION 1980-81

Position and Dollar Resources
(in $ millions)



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources Administration

BIOGRAPHICAL SKETCH

NAME :	Robert Graham
HOME :	Prairie Village, Kansas (Born: Pueblo, Colorado)
DATE OF BIRTH :	February 15, 1943
EDUCATION :	Earlham College, Richmond, Indiana, A.B. Degree, 1965 University of Kansas School of Medicine, M.D. Degree, 1970 Resident in Family Practice, Baptist Memorial Hospital, Kansas City, Missouri, 1974-1975
EXPERIENCE	
PRESENT :	Acting Administrator, Health Resources Administration, Department of Health and Human Services
July 1979 - December 1980 :	Professional Staff Member, Subcommittee on Health and Scientific Research, Committee on Labor and Human Services, United States Senate
July 1978 - June 1979 :	Deputy Administrator, Health Resources Administration, Department of Health and Human Services Executive Secretary, Graduate Medical Education National Advisory Committee (GMENAC)
July 1976 - July 1978 :	Deputy Director, Bureau of Health Manpower, Health Resources Administration, Department of Health and Human Services
January 1976 - June 1976 :	On Staff of Program for Health Management, Baylor College of Medicine, Houston, Texas Instructor, Department of Community Medicine, Baylor College of Medicine, Houston, Texas
February 1973 - January 1976 :	Assistant Director, Division of Education, American Academy of Family Physicians, Kansas City, Missouri Administrative Officer, Society of Teachers of Family Medicine

June 1970 -
February 1973 : Assistant Administrator for Agency Goals, Health Services and Mental Health Administration, Department of Health and Human Services, Washington, D.C.

1970 - 1973
1976 - Present: Commissioned Officer, Active Duty, United States Public Health Service

APPOINTMENTS : Consultant, National Academy of Sciences/Institute of Medicine, Social Security Studies, 1974-1976
Advisor, Robert Wood Johnson Foundation, Rural Practice Project, 1975-1979
Consultant - Bureau of Health Manpower, Office of the Director, 1975-1976
Consultant, National Health Service Corps, Office of the Director, 1973-1974
Consultant, Study on the Place of Behavioral Sciences in Schools of Medicine, 1969-1970
Student Consultant, Carnegie Commission on Higher Education, 1969-1970

ASSOCIATIONS : American Academy of Family Physicians, 1973 -
American Medical Association, 1970 -
Association of American Medical Colleges, 1968 -
Society of Teachers of Family Medicine, 1973 -
Society for Health and Human Values, 1969 -
(Member, Executive Council, 1971-1975).

RECENT
PUBLICATIONS : "Political and Legislative Influences on Primary Care"; Banta, H.D. and Graham, R.; The Mount Sinai Journal of Medicine, Vol. 45, No. 5, Sept.-Oct. 1978.

"National Policy Towards the Foreign Medical Graduate: The Legislative History, the Policy, and How it Will Work"; Proceedings, Health Policy Forum, Foreign Medical Graduates in New York, City, United Hospital Fund, Feb., 1979.

"Public Policy Implications of Graduate Follow-up Studies in Family Practice", Graham, R., The Journal of Family Practice, Vol. 11, No. 5, October 1980.

INTRODUCTION OF ASSOCIATES

Dr. GRAHAM. Before going any further, I would like to introduce the individuals who have accompanied me this morning.

At the left is Mr. Tony Itteilag, who is the Acting Deputy Assistant Secretary of Budget; to the right is Dr. James Walsh, who is the Associate Administrator for Operations and Management; from your left, immediately behind me, is Dr. Colin C. Rorrie, Jr., who is Director of the Bureau of Health Planning; Mr. Thomas Hatch, Director of the Bureau of Health Professions; Dr. Florence Fiori, Director of the Bureau of Health Facilities; and Dr. Clay Simpson, Director of the Office of Health Resources Opportunity.

If I could, sir, just very briefly provide you with an overview of the agency and our programs and then go to any questions you may have.

OVERVIEW OF HRA

The Health Resources Administration was created in 1973 as part of the Public Health Service reorganization with the specific mission of providing leadership and support in assuring the resources, information, personnel facilities, and services that are necessary to support the health of the Nation are accessible, appropriate, and affordable.

By the nature of our charge as an organization, we are highly concerned with the next 5- to 10-year future of the health care system and how to anticipate the challenges which we will face during that period.

Rather than go into detail about any number of our programs, I just want to give you a brief overview of the four major operating components and illustrate in each area, by a chart, the national impact of at least one specific program.

HEALTH PROFESSIONS EDUCATION

In the Bureau of Health Professions, directed by Mr. Hatch, we monitor the overall supply of health professionals, nurses, and allied health personnel. We provide targeted special projects that address high-priority health professional development activities.

We address the needs for health professionals in underserved areas and we provide special emphasis on the training of family practitioners, primary care, internal medicine, and pediatric specialists, physician assistants, and nurse practitioners.

AREA HEALTH EDUCATION CENTERS

A specific example of the programs carried out by the Bureau of Health Professions is the area health education center program which we have been operating since approximately 1973.

At the present time we are supporting some 21 area health education center programs. These projects are partnership projects between the Federal Government, State government, private and public institutions within each of the States, and provide for the increasing distribution of health profession trainees in those States and regions with the hope that more individuals will enter into shortage-area service and shortage-area specialties.

The Office of Health Resources Opportunity, headed by Dr. Simpson, coordinates for the agency strategies for assuring access of the disadvantaged to both health careers and health care services and supports specific projects directed toward increasing minority participation and enrollment in health professions education and allied health training and thus supports projects at three levels, community-based preprofessional schools and professional schools.

The second chart illustrates the progress in the support of this program over the 8 fiscal years it has been in operation and it gives you some idea of the numbers of States and the numbers of projects which that program has provided support.

HEALTH PLANNING

The Bureau of Health Planning, directed by Dr. Rorrie since 1975 has operated as the Federal focus for the implementation of the health planning statute which presently supports 204 community-based health systems agencies, 57—9 of these jurisdictions receive HSA funds under section 1536 of the act—State health planning and development agencies.

The chart illustrates for you that there are in the United States presently 42 States with certificate of need programs that are conforming to the provisions of the Federal statute. There are 13 States which have certificate of need programs, but at the present time are not conforming to the present statute, and only 1 State at the present time, Louisiana, and 1 territory, the Virgin Islands, that do not have a certificate of need program at all.

HEALTH FACILITIES

The Bureau of Health Facilities, headed by Dr. Fiori, was created in 1978 to provide a special focus for responsibilities within the Department to monitor the overall status of health facilities and specifically to address the aggregate need for health facilities and beds in the next 10 to 15 years.

It is also the responsibility of the Bureau to monitor the status of the portfolio of Federal grants, loans, loan guarantees, and loan subsidies to assure that the Federal interests are protected.

Also the Bureau assures that uncompensated care is being provided by institutions that are obligated to the Federal Government by law, by nature of the contract or grant or loan it may have entered into.

The chart here provides you with a rundown by region and by State of the level and activity and responsibility of the Bureau of Health Facilities at the present time, both to monitor the loans, as is shown on the right side of the chart, and the numbers of hospitals in each State that are obligated to the Federal Government for providing free care assurances, which again we must monitor by statute.

Programmatically, that is a quick overview of the agency. The last chart provides you a graphical depiction, under the present continuing resolution provided to the agency, of our dollars and positions for fiscal year 1980. And the fiscal year 1981 continuing resolution dollars and positions.

I hope that quick overview has given you a useful summary of our activities and I would be happy to address any questions that you have.

Senator BURDICK. Thank you for the overview.

EFFECTIVENESS OF PLANNING PROGRAM

You are no doubt aware of the administration's proposal to phase out health planning by 1983. In the proposal for economic recovery the administration states that the health planning program represents an effort to impose a complex national health regulatory program on States and localities and has not proved effective in controlling costs on a national basis. It inhibits market forces needed to strengthen competition to provide less costly service.

This is a strong indictment on the health planning program. Can you comment on these charges.

Dr. GRAHAM. I think the comment I would have is that we understand that President Reagan does have very strong feelings in this area. That is part of the philosophy of the administration which the people have elected to carry out the programs over the next 4 years. We understand that point of view.

COMPETITION IN THE HEALTH FIELD

Senator BURDICK. Do you really think that market forces apply in the health field?

Dr. GRAHAM. I must admit I am not an expert economist. I know that there is substantial difference of opinion in the field and has been for the last 4 or 5 years as to the effect of market forces and whether or not such activities as certificate of need programs are helpful. But I think what we face now is an attempt, an experiment on the part of this administration, to carry out these activities in a different way than has been done before.

CAPACITY OF STATE AND LOCAL LEVELS TO OFFSET FEDERAL REDUCTIONS FOR HEALTH PLANNING

Senator BURDICK. To what extent would the States and localities take over health planning if the Federal program is abandoned?

Dr. GRAHAM. I would like to ask Dr. Rorrie to answer that question at more length, because he is more intimately familiar with the status at the State and local levels. To just give you a quick response, at the present time there are roughly 50,000 individuals that are formally involved in the health planning process at either local or State levels. A number of them and a number of other private entities may continue health planning activities under a different aegis. In those areas, it may well be that we will see a continuation of either a local or statewide planning effort. But the absolute degree of investment or the shape of that continuation I think would be very much a State or local option.

Let me see if Dr. Rorrie has additional comments.

Dr. RORRIE. No.

EVOLUTION OF HEALTH PLANNING—PUBLIC/PRIVATE

Senator BURDICK. You know, since I have been in the Congress—that's a long time—it's the other way around. The States are coming here constantly for help. I am just wondering how much they will respond if we don't. That is a practical question.

Dr. GRAHAM. It is one that I don't have a quantifiable answer for. However, as a matter of historical perspective, I believe, and again I will turn to Dr. Rorrie on this, that even before the Health Planning Act was passed in 1973 some States were already embarked upon programs that were attempting to do local- or State-based planning and sometimes a certificate of need review. It existed even before the Federal presence. So I think there may well be some kind of continuation.

Dr. RORRIE. The planning philosophy goes back to the 1930's. In the 1940's there was very strong local participatory emphasis on planning in this country, largely from business corporations who really started the planning philosophy in this country. What we have seen happening over the last year, because of the pressure of costs, is that there is an increasing number of business coalitions developing around the country. We can map out over 30 coalitions right now. Most of those coalitions are less than a year old, and there are new coalitions forming on a daily basis.

Two of our agencies in Portland, Oreg., and Denver, Colo., asked for help in putting together those structures.

Linked to those have been a number of labor organizations coming in. Also because of the cost issue, it will vary throughout the country. But we assume a number of those coalitions will pick up for the planning activity at the local level. I think, on the other hand, at the State level, by shifting a number of the programs back to the States, within the context of a block grant, which the administration is proposing, you will find that States will now be placed in the position of having to insure with the resources that they have that they get full value for the dollar. So we expect that we will see an increasing number of regulatory tools at the State level to deal with this issue.

PLANNING RELATIONSHIP TO BLOCK GRANTS

Senator **Burdick**. You are correct that there will be some assets available in the block grants, but there will also be a lot of competition among the various forces for those dollars and no assurance at all about how much will go into planning then.

Dr. **Rorrie**. The States will have to make sure they have some mechanism such as the planning program to make sure they get full value for the dollars that they have.

IMPACT ON HEALTH CARE COSTS AND ACCESS TO CARE

Senator **Burdick**. Well, we will have to wait and see.

If the administration's plan succeeds, what will the impact on health care cost be? Will it be higher or lower? Changing any?

Dr. **Graham**. I think central to the strategy that the President is laying out is that the work of the market and competitive forces will stabilize health care costs. That is the assumption behind this program.

Senator **Burdick**. I will put that down as the assumption.

What impact do you think the cuts will have on the ability of the health care delivery system to reach those who are underserved?

Dr. **Graham**. Again, it is difficult for me to give you a quantifiable answer, and we are now in an area where we are not necessarily dealing entirely with health planning issues. We are talking some about the health services programs of the Department which are not necessarily the responsibility of this agency.

To go back to a block grant strategy and to put that in the context of an overall economic strategy, I think the feeling on the part of the administration is that you try to put more of the public resources or tax resources at the disposal of local decisionmakers rather than the Federal decisionmaker and at the same time you try to stimulate the economy so there is fuller employment and so that the benefits provided by employers are broader, and that this is the way that you address the persistent needs of underservice.

Senator BURDICK. One of the things that I am concerned about, in the plans which you and your associate have described, in this country, in these wide expanses of rural areas is that the doctors just aren't there.

Dr. GRAHAM. I can be sympathetic with that concern. Although I come from an urban part of Kansas, it is not terribly different from the other parts of the Midwest and the Far West. I think what we are talking about is not abrupt cessation of these programs. We are talking about a phaseout over 18 months, or 24 months. And it is the feeling on the part of the administration that this will give the other programs a chance to come on line.

NURSING SHORTAGES

Senator BURDICK. A little later I am going to talk about doctors in rural areas. The administration's budget proposals call for support for nonphysician training where shortages persist. Nursing is mentioned as being in this category. Any comment about proposals that affect that area?

Dr. GRAHAM. Well, I think my comment is that this administration, I believe, will be taking a somewhat different position. Nursing supply has been a problem, and it has been a problem for the last 10 years.

There are many aspects to the problem and I don't think any of us would presume to say we have the answer. Over the last 10 years the supply of nurses graduating from the schools of nursing with associate diplomas, or baccalaureate degrees has increased markedly. But at the same time, there are areas in the country, whether they be rural or inner city, where it is very difficult to get nurses for some or all shifts. And it is a particular problem in long-term care.

I am convinced that this administration is going to look at the issue of nursing supply very carefully, not assuming that simply because the number of graduates has been increasing that this, perforce, solves all the problems. Now, whether or not that means we need more graduates or whether we need different strategies to effectively recruit more of the graduates into the nursing pool to participate as clinical nurses, I don't know. In other words, seeing that there are hospitals which do not have adequate numbers of nurses does not in my mind necessarily mean, at this point, that we have to increase the output of nursing schools. That may not be the right answer. But I think there is no longer any argument about the fact that there are persistent nursing shortages at the delivery end, and we must address that.

Senator BURDICK. That leads me to the next question, then. You are aware of these shortages of trained nurses, but some of the numbers we have received indicate that you plan a $54 million cut in nursing training programs this fiscal year. How does this square with the administration's claim of concern over nursing shortages?

Dr. GRAHAM. The cutbacks that would be generated this year and next year would come from the parts of the nursing program where, in the judgment of the administration, they are not addressing the supply issue. We have over the past 4 to 5 years made substantial investments in a whole variety of nursing activities. There has been institutional support. There has been support for special training at advanced levels of nursing, both in terms of nurse practitioner programs and faculty development.

We will have to back off from these types of programs because of the economic realities that we face. However, we will maintain a Federal presence.

To deal with the supply issue that I mentioned before, we will retain the nursing special project grants. This will help us to address the issue of why it is, in the face of past increases in enrollments and graduations, we still have these shortages of bedside nurses.

Senator BURDICK. So you don't think that a cut of $54 million in the nurses' training program will exacerbate the situation?

Dr. GRAHAM. Well, being a good bureaucrat, I always hate to see programs cut, particularly programs in which I think we're doing a good job. However, given the economic realities that we face, I think we can understand why the President has taken this position. However, the cut in those programs I see as being a separate issue from the total supply at the bedside. I'm not sure that the linkage between aggregate supply of nurses as they graduate from the nursing schools and the problems that we have with making sure there are nurses in the hospitals where we need them is an absolute linkage.

That's an area where we need more information, and we are still, under the President's budget, in a position to get that information.

COST EFFECTIVENESS OF HEALTH PLANNING

Senator BURDICK. One of the most consistent charges raised by critics of the health planning program is that it costs more than it saves, not only in direct operating costs of the health planning entities themselves, but also in terms of indirect costs associated with the imposition of regulatory controls over the health system.

How cost effective are the activities of the health systems agencies, the HSA's?

Dr. GRAHAM. Again a question to which I would like Dr. Rorrie to address himself. Just briefly, I would say that the cost effectiveness is difficult to measure. We have a variety of studies at both the local and State agency level which indicate that there may be some cost effectiveness. However, my understanding of the administration position which you and I have been discussing is not that planning is being discontinued because of the failure of cost effectiveness but over a philosophical difference about the role of the Federal Government.

Colin, I think we do have some data on cost effectiveness.

Dr. RORRIE. Our analysis over the last year shows that about 450 million dollars' worth of projects were disapproved through the planning process. Another 200 million dollars' worth of projects were withdrawn; that is, they never went through the system. That's one of the things—when you look at cost effectiveness in the program, one of the difficult things to measure are those projects that never go through the system. The figure I gave you, $450 million, were projects that actually formally went through the system and were turned down. What is difficult to calculate are projects that providers never submitted through the system, because after consultation with the planning process, they realized there was an excess of obstetrical services or in-patient acute care beds; therefore, they did not put that project through the system.

With the cost of inflation, a projected building that would have a 30- to 40-year life is very difficult to calculate in terms of the overall costs. So the system is saving money. So what we're really left with in most respects is calculating the projects that actually do go through the system. And in fact, if we do have a good regulatory system where there is a substantial amount of prior planning going on, we should only be getting projects coming through the system which, in fact, are really needed.

In those cases, we would only have a very few projects where a provider elected to go through the system, even though there was forewarning that the projects were in excess. So that's the difficulty that we have. I think the data shows that there has been an increasing amount of activity in the cost savings area. The thing you have to realize is that most of these programs, the certificate of need programs in particular, are about 2 years old in most States. That is, they've really been up and running over the last 2 years, and some of the data does show that the agencies that have been in operation for a longer period of time do, in fact, have a stronger track record than those that have just started.

Senator BURDICK. I presume that some of those projects have been rejected and should be rejected; isn't that right?

Dr. RORRIE. Yes; unneeded projects should be rejected.

Senator BURDICK. When you send a plan up, it's the duty of people in authority to examine it and see whether it's practical and effective. But that doesn't mean that there aren't many other projects that do go through.

Should the primary goal be the reduction of the rate of increase in health care costs, or are other goals also important? I'm talking about the goals of improved access to primary care and the restructuring of the health system to improve quality of care. Any comment?

Dr. GRAHAM. I think that's a question to which it's impossible not to answer "Yes." The goals that we must face federally in terms of our responsibilities must look not just at costs but also at accessibility and the proper mix of health professionals in the proper place. I think we must continue to address those issues.

REGULATORY BURDEN

Senator BURDICK. Some critics contend that the health planning program merely adds regulatory costs to the system without providing significant benefits. Planners and lawyers must be hired, justifications prepared, instead of the development costs incurred by facilities wishing to obtain improved or new services that the community may want in any event.

What's your comment on that?

Dr. GRAHAM. It would be hard for me to add anything to the exchange you and Dr. Rorrie have already had.

COST VERSUS ACCESS

Senator BURDICK. Other observers feel that the health planning program suffers from too much emphasis on cost control, losing sight of other equally important services such as availability and accessibility of services, improved quality of care, and so forth. These observers note that outside the major metropolitan areas, cost issues are often a less urgent concern than the accessibility of primary care or development of alternatives such as mental health centers and long-term care programs.

Do you have any comment other than what you've given already?

Dr. GRAHAM. I think that is a fair comment in terms of the subject of the health planning program, but it may not be a fair description for a variety of reasons. It's become labeled in the last several years as primarily a cost containment program, which at least in my reading of the act passed by the Congress, was not its main emphasis; it had a much broader emphasis.

I'm impressed with the extent to which the local agencies and to a similar extent the State health planning agencies really are, in their planning and development, looking at the issues of access and primary care.

Colin, you've got a lot more data than I have.

Dr. RORRIE. Again, I think as you have pictured the situation, there are significant parts of this country where costs are not the predominant issue. If you go out to your part of the country and moving west, energy exploration, the MX missile development, those issues are predominant issues in terms of access—what those communities are concerned about, communities that have 1,000 to 2,000 people today and 4 years from now are going to have 55,000 people in those communities, how their health care needs are going to be addressed.

The planning agencies in those areas have addressed those considerations. But even in parts of this country where costs are a predominant issue, there have also been access considerations. In the center cities, infant mortality has been a major problem. HSA's have been working with local health departments to deal with that, and we have produced a series of health planning accomplishments which the committee will want to look at from across the country, to look at both from the cost side as well as from the access side—the types of things that HSA's and States have been working on.

Senator BURDICK. The document you referred to will be made part of the file without objection.

RELATIONSHIP OF PLANNING TO LOCAL/STATE GOVERNMENT

In many areas of the country local health departments develop health programs and services for their community. To do this, they must have information on the health needs of their community and the services already available. To what extent do these local health departments duplicate the planning efforts of the health system agencies, HSA's? Or is there cooperation and interaction between them?

Dr. GRAHAM. My impression is that there is relatively little duplication and relatively great cooperation. Again, Colin, could you speak to that?

Dr. RORRIE. I believe it varies throughout the country. That's the nature of this program. It's a local program; it varies according to the conditions. In certain communities where a local government has had financial problems and they've had to cut back on their overall health budgets and health operations, as we have seen in many places, one of the first things to get cut back in an operation is the planning and research capacity.

The local HSA's in many communities do serve that function for local health departments in terms of a definition of needs and priorities. The thing that's interesting is that we have looked merely down towards the planning process, and looking to what extent is it servicing the needs and priorities for local communities, but it's a resource tool that we in the Federal Government have not looked upon very much either. That is the national network of planning agencies and the extent to which we can extract information on what the real needs and priorities are across the country, which we're in the process of doing right now.

Senator BURDICK. Based on your experience, have you noted any friction, noncooperation, between the HSA's and the local medical planning groups? Or do they generally cooperate?

Dr. RORRIE. Again, it varies. I'm not going to take the position that it's all roses. There are points of friction; maybe more of that at the State level between the State health departments and the State planning agencies, particularly when the planning agency is part of another part of State government such as the Governor's office or the Department of Human Resources. They often don't have the integration that we would like to see.

Senator BURDICK. What are they doing to minimize the friction, if you know?

Dr. RORRIE. I guess the best way you try to minimize friction is to talk and try to show that everyone is facing declining resources, and with the resources that are available, you try to get the most out of it. You don't get the most out of it by fighting; you try to put your mutual energies together.

Senator BURDICK. Has the Department taken the lead or the initiative in that regard, do you know?

Dr. GRAHAM. I think what Dr. Rorrie has outlined to you can be seen in sort of the context of the State health departments and the human resources departments exist in the State and are required by existing law in the State.

Since health planning activities have come online relatively recently, we've seen something of a settling out and a shaking down of responsibilities. It is simply a process of maturation of the health program.

The Department has not in any direct or heavyhanded way tried to say, "Look, you've got to do this; you can't do that." But we have tried to emphasize in working with our State health planning agencies, that it is important that the plans they develop for effective implementation be as much as possible consensus plans, that they work effectively with the power structure within that State.

Dr. RORRIE. I think we should also point out as part of the governing body composition of the local health systems agencies, that there is representation from local government on them.

Senator BURDICK. A little overlap?

Dr. GRAHAM. Yes.

STATE CERTIFICATE OF NEED PROGRAMS

Senator BURDICK. Since certificate of need reviews are basically a reactive process which passes judgment on only those facilities and equipment items that are proposed, isn't it really a regulatory and planning function? What sort of costs do institutions incur in responding to a certificate of need review?

Dr. GRAHAM. We are not sure about what the incremental cost is that can be ascribed simply to certificate of need. Obviously any institution, particularly the complex institutions that we're dealing with here, have to have their own internal planning process. They have to know, or they should know, where they're going in 5 or 7 years before they bring the facilities online.

So they must have some understanding of what's going on in the certificate of need process and sharing that information with the community agency and sorting out what the relative community priorities are. I know of no way to get the incremental costs, but I don't think it is fair to ascribe it totally to the certificate of need process—the total cost of planning which we would expect to go on in the institution, whether the certificate of need process was there or not.

Senator BURDICK. Because the State has final approval authority over certificate of need reviews, what would you lose by giving the total responsibility to the States?

Dr. GRAHAM. Well, I think that is what we face—and obviously this is part of the administration's plan for the planning program. There may well be a continuation of the CON process at the State level.

But at least one level of comment where the facility or the equipment is to come online may not be available, at least in the same structured way that it is now.

APPROPRIATENESS REVIEW

Senator BURDICK. As we understand it, the essential purpose of an appropriateness review is to examine a health care facility in a community to determine whether it is needed. What about the practicality of this function? To what extent are providers reluctant to provide data that highlights inappropriate facilities or services?

Dr. GRAHAM. The degree of reluctance again I would place in the historical context of a relatively new bill, a relatively new activity. In any community, whether we're talking about the medical community or any type of organization, there is a reluctance to change patterns; there's a reluctance to share influence, as obviously we have been asking under the direction of the act.

I think that as the appropriateness review has come online, and realizing that even though under the provisions of the Health Planning Act this is a relatively new activity, it was oriented in the first 2 or 3 years to getting the agencies identified, organized, and designated so they could start acting.

Appropriateness reviews are something you can carry out only as you get into that functional mode. There has been, differentially, in different parts of the country, some reluctance to share data, some tendency to question the appropriateness of the role of the HSA or of the State agency. But again, historically I think we see less friction in those areas where the agencies are maturing and where they are doing a good job of working cooperatively.

ACCESS TO DATA

Senator BURDICK. It's obvious that if the health system agencies are to do their job, they must have an adequate data base and access to legitimate new data. To what extent have HSA's had to file freedom of information suits to acquire Federal program data from Blue Cross intermediaries or other intermediaries to the program?

Dr. GRAHAM. I'd like Dr. Rorrie to respond to the specifics of that. I'm unaware of those suits.

Dr. RORRIE. Generally we've had no problems. Over the last couple of years, working with HCFA, we've been able to access a lot of the HCFA data that has been put together, and that has started to be made available. I'm aware of one suit in Georgia where the HSA did bring suit to get Blue Cross as an intermediary to provide data. I don't have the outcome of that suit.

Senator BURDICK. When you receive the information of the number of suits and where they're filed, if you have any additional knowledge of any other areas besides the one you referred to, if you would supply it for the record.

Dr. GRAHAM. We'd be happy to supply it for the record. I do not have any additional information now.

Senator BURDICK. And you don't know the outcome of that lawsuit?

Dr. RORRIE. No.

Senator BURDICK. Was that in Federal Court?

Dr. RORRIE. I'm not sure.

Dr. GRAHAM. We'll supply additional information on that specific issue for the record.

Senator BURDICK. Fine.

[The information follows:]

LAWSUITS

Health systems agencies have had difficulties in acquiring local professional standard review organization data, PSRO's are a source of hospital discharge data needed by HSA's to estimate utilization and resource use patterns. The issue of whether PSRO's are subject to freedom of information is currently pending judicial consideration. HSA's, for the most part, have had to do without PSRO data.

The previously referred to incident in Georgia is an example of an HSA threatening to use the freedom of information channel, but failing to follow through. We do not have specific data on actual filings to HSA's to gain data under the Freedom of Information Act.

HOSPITAL FREE CARE

Senator BURDICK. How many hospitals and other health facilities are still under obligation to provide so-called free care or uncompensated services to indigents as a condition of Federal assistance?

Dr. GRAHAM. I think we have a considerable number of institutions in all parts of the country. Dr. Fiori has the exact numbers.

Dr. FIORI. I'll use approximations. There are about 5,000 facilities that still have an uncompensated care obligation. The majority of them are hospitals, but some of the numbers included in that group are public health centers, public health laboratories, and other such facilities.

Senator BURDICK. Would you please identify yourself for the record.

Dr. FIORI. I'm Florence Fiori, Director of the Bureau of Health Facilities.

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE (GMENAC) REPORT

Senator BURDICK. Thank you. The Graduate Medical Education National Advisory Committee, the GMENAC, reports that there will be a surplus of about 70,000 physicians by 1990. In view of this, to what extent can the funding for medical school capitation grants be justified?

Dr. GRAHAM. In the view of the administration, it can't be, and it is proposed that capitation funding be discontinued.

Senator BURDICK. Do you think the projection is accurate?

Dr. GRAHAM. Any projection of that nature is very difficult. My personal feeling is that the GMENAC process was a highly responsible one. It involved a large number of individuals from all parts of the profession and outside the profession, including consumers and State and local government representatives. I find it to be a reasonable projection. It may not turn out to be right, but I don't think, if there is any error on one side or the other, it is because of carelessness.

FEDERAL ASSISTANCE FOR HEALTH PROFESSIONS EDUCATION

Senator BURDICK. What role does such Federal assistance continue to play in health professions education?

Dr. GRAHAM. I believe the role that we see for continued Federal involvement is going to be a highly targeted one, specifically toward the areas of primary care: Making sure that we have adequate numbers of family physicians; other types of primary care providers; and that to the best of our ability, we encourage the educating institutions to continue to allocate resources to this type of training, and to attempt through the area health education center programs and other types of programs, to assure that individuals so trained to distribute themselves throughout the country so that they are accessible to the people.

PHYSICIAN DISTRIBUTION

Senator BURDICK. Coming from a rural area, I am very much concerned that although we may have the numbers of doctors, we may not have the distribution. Do you have any plan to get any better distribution?

Dr. GRAHAM. I think North Dakota is a good example, and it is a similar example that we can find in almost every State, even nonrural States. If you talked to people in your State, or Kansas, or others, 10 years ago, 15 years ago, you would find a level of concern that the most accessible point of medical care, that is, the office-based practitioner, whether it was the general practitioner or general internist, was slowly disappearing from the small communities. As they became older, retired or died, they were not replaced.

Well, what we have seen in the last 10 years has been something of an across-the-board attempt to address that circumstance. A lot of it has been in medicine. We have seen the resurgence of family practice as a specialty; we have seen some redirection of internal medicine and pediatrics; we also have nurse-practitioner programs and physician assistants programs. The State of North Dakota now has five family practice residency programs, where 5 years ago it had only one or two.

We do find, and I know North Dakota's experience in this is similar to that in other States, that individuals educated in those institutions, educated in those community hospitals, stay in the State and practice in the smaller communities in disproportionate numbers to any other types of practitioners. I think we are gaining on that.

Senator BURDICK. You know what I've had to become? I've had to become an expert on immigration, not on health care, to provide doctors for North Dakota. Right now I've got an application pending, a doctor standing on the edge of the border wanting to come into the community. The community wants him in, and I've got to fight with immigration. So I had to learn a whole new expertise to get the doctor into North Dakota.

FINANCIAL DISTRESS FUNDING FOR MEHARRY MEDICAL SCHOOL

What is the status of your continuing support for the Meharry Medical School under the financial distress program? We understand this sort of support can go on for years. What can you tell us about this?

Dr. GRAHAM. The Meharry issue is a very complex one, and it's been one that the Department has been consciously addressing for at least the last 3 years. We are presently supporting Meharry in a number of ways. There is financial distress funding; there is funding through a subsidy of their loan payments on the loan that they have for the teaching hospital. There are also special project grants which the college has competed for through the Public Health Service.

There is in the Department a task force that is specifically looking at what our responsibilities and options are about the college. It is the concern of this task force that the Department play a partnership role with the college, with the local community, and private philanthropy to find an equitable solution for the college's financial problems.

We are optimistic that this sort of partnership arrangement, with an appropriate Federal role, will eventually resolve the issues that face the college.

Senator BURDICK. We understand this sort of support can go on for years; as a matter of fact, we've heard the figure 30 years. What can you tell us about that?

Dr. GRAHAM. I think before I respond, Mr. Itteilag wants to respond to your prior question.

Mr. ITTEILAG. I must say, Senator, that the new administration has, as one of its goals, consideration of this very matter. There may well be a change in policy in the administration with respect to this program. I think that we will be able to speak more authoritatively and more accurately with respect to Secretary Schweiker's position after the remainder of the Reagan budget revisons are made known in detail on March 10.

DENTAL TEAM PROGRAM

Senator BURDICK. Referring now to the dental team practice, why can't the dental school assume financial responsibility for this program?

Dr. GRAHAM. I think part of the assumption implicit in the budget proposal by the administration is that it is not only possible, but desirable. But for some of the specifics about the degree of present support of this program by the schools, I would like to turn to Mr. Tom Hatch, who is the Director of the Bureau of Health Professions.

Mr. HATCH. The current program is at the level of about $2 million a year. It supports 12 schools currently. Since 1972, grants have been awarded to 40 of the 60 dental schools, and have provided training for about 25 percent of all the dental graduates since 1972.

FEDERAL SUPPORT FOR TRAINING PUBLIC HEALTH PROFESSIONALS

Senator BURDICK. With all the higher education student assistance programs on the books, why is it necessary to continue to provide the Federal support for training public health professionals?

Dr. GRAHAM. The reason that we would continue this program, even at a reduced level, is that public health professionals are a very special resource. They address both the issues of the integration of systems by participating in State and county public health departments, and they are more likely to address some of the issues of the need for preventive medicine, health promotion. We feel that it is appropriate for the Department to continue on a limited basis to support both the schools and the training in those schools of public health.

Senator BURDICK. Programs for public health traineeships and health administration traineeships are separate, but both provide assistance for, among other things, training in health administration, health policy analysis, and health planning. Why do we need two separate programs, and why couldn't they be consolidated?

Dr. GRAHAM. Although the specifics of that item in the budget are still to be fully resolved, I think you will find a degree of consolidation that does not now exist.

GMENAC FINDINGS ON SUPPLY OF PRIMARY CARE PHYSICIANS

Senator BURDICK. In light of the recent findings of the Graduate Medical Education National Advisory Committee—there's a long one—that the supply of primary care physicians will be in near balance by 1990, how much longer do we need to continue Federal financial support in this program, family medicine?

Dr. GRAHAM. The assumption of the GMENAC committee was that we would come to a functional balance in the primary care area by 1990, if Federal support continued. So they assumed a steady state of Federal support in their projections. For Federal support to be markedly changed, you would have to assess the nature of that change and the degree to which those programs would be able to continue. But it could have some influence on GMENAC's predictions that we would have an adequate supply of primary care physicians by 1990.

GERIATRIC MEDICINE

Senator BURDICK. I have authored a bill that would encourage medical schools to establish programs of geriatric medicine. As you know, the Senate health manpower bill incorporated and expanded this idea in their bill last year, and interdisciplinary grants had some money for geriatric programs a few years ago.

First, can you tell me if those programs were considered a success? Second, do you see a need for the Government to encourage geriatric medicine in medical schools? And what about nursing and pharmacy schools?

Dr. GRAHAM. Let me respond to the latter portion of your question first. We do find the issues of geriatric care very important. That is one of the reasons why in all the primary care programs, that we support our guidelines specifically required that these areas receive priority attention. As to the specifics of those programs, Tom could you give them?

Mr. HATCH. Yes; as Dr. Graham has indicated, in addition to giving emphasis to this in the programs such as family medicine, area health education centers, nurse-practitioners, and special projects, we've also been supporting, over the last 2 years, a program specifically designed to stimulate the development of curriculums in geriatrics in medical schools. This program currently supports about 25 such projects throughout the country.

AREA HEALTH EDUCATION CENTER (AHEC) PROGRAM

Senator BURDICK. A little comment in here at this point, too. The University of North Dakota Medical School is very high on this program, and I see the merit of it. How successful has the AHEC program been? What evidence can you cite?

Dr. GRAHAM. Again, for some of the specifics I would like to turn to Mr. Hatch, because we do have, I think, good data from a number of States about the impact of the program. But overall, I would have to say that it is my judgment that that program has been an effective program in both reorienting the contracting institution to greater commitment to primary care and on-site training; to matching Federal funds with some of their own funds, so after the Federal funds go away the programs continue to operate. And that it's having an impact on the type of training offered by those institutions.

As to where the participants of the AHEC program actually choose to practice—Tom, do you have some specific data?

Mr. HATCH. Yes, sir; last year we submitted a report to the Congress on the evaluation of the area health education center program. The data supported the successes, although it would be fair to say it is sometimes difficult to quantify some of the kinds of activities, particularly things like continuing education. The evaluation that we submitted last year indicated that in counties where area health education center programs were in force, the increase in the number of primary care practitioners was significantly greater than in similar counties which did not have such programs.

A recent Carnegie Commission report also indicated that the area health education center program has been successful.

Senator BURDICK. It would appear from the Reagan budget that AHEC may be cut by $6 million in 1982. Is this correct?

Dr. GRAHAM. I would like to, at least for my part, defer any comment on the specific numbers in the budget, because I know that Secretary Schweiker is still in conversation with OMB about some of the specifics of the Department's budget. But Mr. Itteilag may want to comment on it further.

Mr. ITTEILAG. I think, Mr. Chairman, that that is the correct comment. We are still discussing the details of this part of our budget with the Office of Management and Budget, and have not yet reached a conclusion.

Senator BURDICK. Would you let us know when you can do it?

Mr. ITTEILAG. I will let you know as soon as the President and the Director of the Office of Management and Budget make their final decisions.

ADEQUACY OF SUPPLY OF NURSES

Senator BURDICK. Very well. What is the evidence which led you to eliminate most of the nursing programs in 1981 and 1982?

Dr. GRAHAM. I think this refers to a prior point which you and I discussed, and that is a large number of the nursing programs that we were able to support in earlier years addressed the specific needs in nursing for advanced nurse training, for expanding some of the functions of nurses, and providing faculty support.

Given the economic constraints of the general budget, we have felt that the highest priority is the issue of effective nursing supply at the bedside, and we have opted to use the amount of funds that may be available to us for that priority.

Senator BURDICK. If we already have enough nurses, why do so many hospitals say they are short of nurses, and why do we see recruitment bonuses for new nurses?

Dr. GRAHAM. I didn't say we have enough nurses.

Senator BURDICK. Didn't you?

Dr. GRAHAM. No; the distinction that I think we must make is that we know we have a problem with what I will call effective supply of nurses at bedside in hospitals on some shifts and in long-term care facilities. We know that we have this continuing problem, even in the face of a rather dramatic increase in the enrollment in nursing schools over the last decade. So some can argue that we have an adequate supply of nurses, simply by looking at the aggregate figures. But we know we have an effective shortage in some areas, geographic, by shift, and by place in the city. It is this latter problem which we will be addressing and looking into to find out if simply more numbers is the answer or whether we have adequate numbers coming out of the schools.

But we must do other things to make sure that they get to the point where nurses are needed. So I would not want to leave you with the impression that I am trying to answer your question by saying we have adequate graduates and there is no problem. It is a priority of Secretary Schweiker, to look into why we don't have nurses where we need them.

Senator BURDICK. When I was in Fargo a couple of weeks ago I went into the hospital. The head nurse gave me a pretty sorry story about how short she was of nurses. If I go back at Easter time, what do I tell her?

Dr. GRAHAM. Tell her that her point of view has been heard, that the Secretary is sympathetic to it, and we are not going to give her a glib answer.

Senator BURDICK. I'll do that.

ADVANCED NURSE TRAINING

The University of North Dakota has applied for, and may have received by now, an advanced nurse training grant and a special projects grant. One is to train instructors at the master's level so the school can maintain accreditation. The other is to provide continuing education for nurses who return to work and want to improve their skills. These are essential to the nursing profession in my State.

What can you tell us about the future of this kind of aid under President Reagan's administration?

Dr. GRAHAM. Again, as a caveat that we do not have the final budget numbers before us, I must say that the highest priority for expenditure of nursing funds will be directed at the issue of nursing supply at bedside. And the continuation of these other activities which we feel very positive about will have to be contingent upon the economic realities.

ENTRY OF FOREIGN DOCTORS INTO THE UNITED STATES

Senator BURDICK. I want to ask you about a problem that's come to my attention. I understand that your agency was not consulted when the Department of Labor amended their rules on the labor certification requirements, to make it easier for foreign doctors to come into health shortage areas. I have two questions on this.

Those regulations were pending for a year. Why didn't HRA have an input?

Two: How could it take you 6 weeks to decide to send letters confirming health shortage? The agency already has the information. It seems to me this should not be a complicated matter. This delay is causing serious problems for communities in my State.

Dr. GRAHAM. Mr. Chairman, I know of your concern on that issue. We were aware, as the Department of Health and Human Services, and as the agency, that there was consideration of this issue in the Department of Labor and there were informal staff contacts, because they were asking us about our data and how it was aggregated and how it was displayed.

But I would have to say that when the regulation was published, we had no forewarning. It had been our assumption that such a regulation that would specifically call for the activity by the Secretary of Education and the Secretary of Health and Human Services would be clearly consultative.

They caught us by surprise. We knew it was pending. We didn't know that they would publish it that soon. When they did publish it there were some changes, and some rather substantial changes in those rules they had imposed, which had an impact on our personnel in terms of what a regional health administrator was supposed to do.

The first that I knew of it was by a call from the committee of the Senate asking us if we were out of our minds for doing this. It then got sorted out that it wasn't the Department of Health and Human Services.

We have tried, as expeditiously as possible, to recognize the personal issues involved, recognize that there are needs for physicians to put together a system which can be administered equitably by all 10 regional offices, and which can provide us with a record of what the transactions are; because I know that I will have to appear before you or others in your position, before other committees, and answer the questions about what we're doing and what the impact is with the influx of foreign physicians under this program. Because there are some people unhappy about this.

I wouldn't be surprised to find out in your State that there are people unhappy. I wouldn't be surprised if I heard in others, about why we are making it easier for foreign graduates to come in, while we are making it increasingly hard for American citizens who happen to be training outside the United States to come in and practice medicine.

So I regret that it appears that the delay of 6 weeks is unreasonable. I feel that this is the minimum amount of time that we needed both to put together an administrative process which is equitable and which would be the same throughout the United States, and at the same time is legally defensible. We have had to consult with our lawyers.

I have every confidence that we will be up and operating with regional health administrators able to make these determinations on certifications, on or about March 1.

Senator Burdick. I can't resist this opportunity to take care of a specific case. If I may, that will be the last question of the morning.

The city of Crosby is a small town, small in terms of the East, a small community, a county seat up in the northwest corner of North Dakota a few miles from Canada. They are trying to get in a doctor. The only one they can get is one from India. He's passed all his tests; he's all ready to come. All he needs is his visa.

There is a long list for Indians from India wishing to get a visa, so they are very anxious for him to apply for it as soon as possible. To get the visa he must have a labor certificate. This is where the problem is.

On December 19 regulations from the DOL expedited the certification process. If the physician is for a shortage area, the community didn't have to advertise. This makes it much easier for foreign doctors to come to the shortage areas. This regulation has been pending for over a year. But HRA says they never were consulted when the ruling was finalized.

There is a bureaucratic problem for which Crosby is now suffering. The regulation became effective January 19, but HRA wants until March 1 to set up a system for certifying to DOL that the area is, in fact, a shortage area. I might say that anybody over the age of 6 knows that this is a shortage area.

They already have this information. What do we have to do to get a doctor for Crosby? We've got one ready to come, fully certified, he's passed all the tests. Now, what's the problem?

Dr. GRAHAM. I really don't think there's anything more that I can say than what I did. Part of my concern, though, Mr. Chairman, is that—I know I'll probably be seeing you again and this issue may come up again—is that we have a system in place, even though it takes us until March 1, that allows me to at least have a chance to answer your question 6 months from now, if indeed that physician is certified and is in the country and has gone to Crosby, about what happened.

What we are very concerned about is, once an individual comes in under labor certification as an immigrant, whether a physician or otherwise, they are not obligated to stay where they have been certified for. And we are very concerned that we have some type of information that we can provide to the Congress about the movement of individuals that we certify. I am concerned that we may have a problem with you, or with other Senators and with their constituents, when we certify a large number of individuals to come in for employment, but 3 to 6 months later we find out that those individuals are not there; that they are in St. Louis or Seattle or San Francisco.

There is no way that we can keep data to assure any town that that won't happen. But I want to at least have a better answer for you 6 months from now if we go through this conversation again, and you say, "What happened? You certified this guy and he came in and he was in the town for 3 months and he took off for San Francisco." I want to have some type of data that I can tell you how much of a problem this is and if we need a change in the law; that we can come back to you and we can come back to the other responsible committees.

As I am sure you are aware, Senator Hatch has written to both Secretary Donovan and to Secretary Schweiker, and has specifically asked Secretary Donovan to remove this regulation and to work with Secretary Schweiker to work out a more equitable way and a more reasonable way to carry out this labor certification process. We are not going to hold the implementation of our part of it until the Secretaries get together; but I think you should be aware that one of your compatriots is very concerned about this, and has asked the Secretary of Labor to remove the regulation.

Senator BURDICK. In all candor, I'll have to agree with you that many of these foreign doctors, whether they're from Canada or the Philippines or wherever, do sometimes stay a short time. But we have no choice. It's either taking a short-term doctor or having none. That's our problem. We have to take the gamble out there.

Dr. GRAHAM. I understand that problem. I hope that we're gaining on that, and we are through AHEC, family practice, and some of the other programs.

Senator BURDICK. I'm not speaking just for North Dakota. I'm speaking for the broad agricultural areas. I understand this is a common problem.

Dr. GRAHAM. I would like to administer a set of programs that assured those individuals that they have some hope of longstanding health care services, rather than a series of 3- to 6-month temporaries.

Senator BURDICK. Would you put my name down in your little book, and I'll call you March 1?

Dr. **Graham**. I don't have to write your name down; I'll remember it.

SUBMITTED QUESTIONS

Senator **Burdick**. I have some additional questions I will give you for the record. Please provide the answers so they can be in the corrected hearing record.

Dr. **Graham**. I'll be happy to, sir.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

HEALTH PLANNING - REAGAN BUDGET

Question: You are no doubt aware that the Administration proposes to phase out Health Planning by 1983. In its proposal for "Economic Recovery," the Administration states that the Health Planning program: "represents an effort to impose a complex national health regulatory program on states and localities, has not proved effective in controlling costs on a national basis, inhibits market forces needed to strengthen competition and provide less costly services." This is a strong indictment of the Health Planning program. Please comment on each of these charges. To what extent would the States and localities take over Health Planning if the Federal program is abandoned? If the Administration gets its way, what will the impact be on health care costs? What impact do you think the cuts will have on the ability of the health care delivery system to reach those who are underserved?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

LOCAL PLANNING

Question: Should the primary goal be the reduction of the rate of increase in health care costs, or are other goals also important? Here I'm talking about the goals of improved access to primary care, and restructuring of the health system to improve quality of care.

Answer: The health planning law allows States and local communities to set their own priorities. We are trying to be flexible and allow the agencies to concentrate their resources on those goals which are most important in their area.

Question: How current are the data examining the cost-savings attributable to HSAs and the Health Planning Program?

Answer: Through our own reporting system, we now keep track of Certificate of Need decisions on an ongoing basis with data that is kept current on a quarterly basis. However, recent evaluation studies have used data that is no more current than 1978. For example, Policy Analysis, Inc., in its econometric evaluation of State CON programs, used data from the period 1968 to 1976.

Question: Is there any indication that the capital market for the health industry is beginning to level off?

Answer: $120-$150 billion is expected to be required for hospital replacement and renovation in the 1980s. This is at least double and perhaps triple the levels of hospital investment required during the 1970s, and this estimate assumes only replacement of existing hospital beds. If totally new facilities are constructed, the investment demands will be much higher. If current trends in hospital financing continue, hospitals will increase their reliance on debt financing to meet these capital requirements. Increasing operating costs and managerial inefficiencies have brought many hospitals to the brink of financial crisis. Many hospitals will find it difficult or impossible to attract the volume of capital needed fom private sources during the 1980s.

Question: What studies are you conducting to determine whether this is so?

Answer: These estimates were developed by the Bureau of Health Facilities, based on current literature. Also HRA supports the "Hospital Cost Model" (a computer model which simulates capital investment decisions) which points to a minumum of $90 billion capital requirement for the same period of time.

HSA STAFFING

Question: How many HSAs are adequately staffed to perform the multiple responsibilities assigned to them?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administrations's policy has been established, it will be provided to the Subcommittee.

Question: Can you document how many agency staff have been affected by cutbacks in levels of HSA funding?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this questions.

Question: Have any HSA functions had to be curtailed because of staff shortages:

Answer: Staff levels have been adequate for HSAs to perform their required functions. Uncertainty about continued funding of the program has damaged the agencies' ability to retain skilled staff. In response to actual and proposed budget cuts, agencies have increased the allocation of staff resources to those functions which are likely to have the greatest impact on the health care system.

Question: How do HSA salary levels compare with those for comparable jobs in the particular community? Bigger? Smaller?

Answer: The Statute (Title XV of the PHS Act, as amended, Section 1512(b)(2)(B)), states "members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities."

Adequate data does not exist to conduct a comparative analysis to measure implementation of this provision since there is a wide variation across the country of salary ranges. Regional Office Grants Management Officers monitor salary ranges of the agencies' local health service areas for similar positions. Furthermore, the broad community representation on the governing body would probably preclude the authorization of salaries not in keeping with community standards.

AVAILABILITY OF DATA FOR HSAs

Question: It's obvious that if the Health Systems Agencies are to do their job they must have an adequate data base--and access, as legitimate, to new data.

To what extent do the activities of the HSAs suffer from an inadequate data base?

Answer: Historically, the issue of building an adequate HSA data base for use in community decision making has been a difficult problem. The planning law places a heavy data gathering and reporting responsibility on planning agencies but does not give them commensurate authority to collect it. Rather, that authority rests with the States. HSAs are prohibited, by law, from engaging in primary data collection and are requiredto use existing data support systems, such as the PSRO and Cooperative Health Statistics System. However, those systems have not provided the data needed by health planning agencies to carry out their statutory functions. By an large, planning agencies have had to rely on voluntary cooperation from health providers to gather needed data, and this has led to fragmented and incomplete data collection efforts for many agencies. More recently, however, effort has been directed at using certain Federal data bases more effectively for health planning (e.g. the HCFA Medicare Statistical Systems). However, these national data bases generally suffer from information which is not current, nor at the required disaggregate level.

Question: To what extent does the lack of sufficient data prevent the HSAs from strengthening competition in the local health system?

Answer: The lack of suitable data to provide consumers with better information to make better choices on their health care is a major problem affecting competition in the health system. HSAs have attempted to deal with this problem in various ways. For instance, they have gathered and are now distributing data on the 25 most frequently used hospital services and hospital room rates in an effort to better inform the public and strengthen competition among health providers. HSAs are one of the few mechanisms in which relevant information on the health industry can be collected and made available to the public. Moreover, HSAs provide the only current local community decisionmaking structure which affords the examination of relevant health care information in an open and public process.

STATE PLANNING AND REGULATION

Question: How many States are in compliance with the requirements of the Health Planning Amendments of 1979?

Answer: There are probably 10 States now in compliance with the Health Planning Amendments of 1979 in relationship to the certificate of need requirements, but none have gone through formal review of legislation and regulations. Most States currently are proposing legislation and/or developing regulations to bring them into compliance.

Question: Do you anticipate having to penalize any State with loss of funds because they are not in compliance with the law in regard to passing acceptable certificate of need legislation?

Answer: The Department has been providing technical assistance to the States as they develop their effective date for compliance, the majority of which will occur early in 1982. We expect that every State will have legislation and regulations that bring them into compliance with the 1979 Health Planning Amendments, and that it will not be necessary to impose the sanction in Section 1521 (d) of the Act. However, if it is necessary due to non-conformance on the part of a State, the Secretary would have to consider applying the sanction as required by the law (unless, as some advocate, the law is changed).

Question: Do the Statewide Health Coordinating Councils play a truly significant role in the planning process or is this entity superfluous?

Answer: Statewide Health Coordinating Councils (SHCCs) exercise a significant role in the health planning process. The statutory functions they perform include:

- establishment of a uniform format for health systems plans;
- review of health systems plans and annual implementation plans;
- revision of health systems plans to achieve better coordination with other health systems plans to deal more effectively with Statewide health needs:
- development and adoption of the State health plan;
- approve or disapprove State plans and applications for federally funded health programs; and
- advise the State health planning and development agency.

The most important responsibility of the SHCC is to coordinate a number of activities; i.e. common format, schedules, data sources, formulas for needs assessment methodologies, thus facilitating the development of the State health plan. This enable States to increase their capacity and role in the health planning process.

The significance of the SHCC's role in the planning process varies from State to State and is dependent upon, among other things, the way in which the SHCC views itself and is viewed by elected and appointed officials at the State level, and the seriousness with which their advice is sought and by State government. In many States the SHCC role is quite strong while in others it is not a successful as it should be.

Question: How effective is the certificate of need process at the State level?

Answer: The effectiveness of the certificate of need program differs in each State. The level of effectiveness depends on a number of factors such as the strength of the State's certificate of need law and regulations and the influence of the State agency responsible for performing the reviews.

If one examines the rate of applications disapproved or withdrawn as an indicator of the effectiveness of a State's certificate of need program the national rate for the period July 1, 1979 to June

30, 1980 has been estimate at 9% of the total applications submitted. The rate of applications disapproved or withdrawn varies from State to State. For example, the rate of applications disapproved or withdrawn during the same period was 46% in Minnesota, 33% in Tennessee and Oregon, and 27% in Wisconsin and Connecticut. There were also a number of States that reported a 100% approval rate for the certificate of need applications submitted.

In addition, certificate of need applications which are approved are often modified during the review process by reducing the cost or the number of beds of a proposed project. One study of the Massachusetts certificate of need program indicated that after 1976, certificate of need review reduced the proposed cost of a project by as much as 2/3 of the originally proposed cost reported in the application.

The major effect of certificate of need programs on the State level has been to discourage unneeded proposals by health care facilities before an application is submitted. In many cases applicants are often advised against submitting an application for an unneeded proposal during the pre-application filing conference between the applicant and the State agency. The result has been increased institutional planning before an application is submitted. Health facilities are more aware of the projected health needs of the community by considering the State and local health plans during the development of proposals requiring certificate of need review.

Question: What is the pattern regarding upholding or reversing of HSA recommendations to the State agency on certificate of need applications?

Answer: State agencies generally agree with recommendations of the HSA on certificate of need applications. During the period July 1, 1979 to June 30, 1980, 96% of the State agencies decisions upheld the HSA recommendations. In those cases where there was a disagreement between the HSA recommendation and the State agency decision, 3% were cases in which the HSA recommended disapproval and the applications were approved by the State agency. The remaining 1% involved applications for which the HSA recommended approval but the State agency disapproved.

Question: How serious are complaints regarding delays in the certificate of need process and also the lag time between certificate of need approval and actual start of the project?

Answer: The certificate of need review period ranges from 3 to 6 months. This time period includes pre-application information, the filing of the application, any requests for additional information from the applicant, and the HSA and State agency review of the application. The length of the review period depends on the State and the type of application being reviewed. An example of one of the longer review periods is found in New York. New York's review period may range from 6 to 18 months because of their cycle for batching applications. It should be noted, that the CON process is part of the entire construction planning process, therefore, the 6 to 18 months would also include other planning activities such as fund raising and review of A & E designs.

The complaints received concerning delays in certificate of need reviews usually involve appeals of applications which have been disapproved by the State. The length of the appeal process depends on the appeal mechanism established under State law. The major source of delay once a decision is appealed is the time by which the appeal will be reviewed by State court.

If the certificate of need application is approved, applicants generally proceed with the project immediately following approval. Applicants often have made all the necessary preparations in order to start construction or to incur the capital expenditure as soon as the project receives certificate of need approval from the State.

APPROPRIATENESS REVIEWS

Question: Are providers required to furnish data that might be used against them?

Answer: Providers are required to provide data requested by planning agencies as long as the agency prescribes and publishes the data requirements in advance of the review. There is no Federal sanction if a provider declines to submit the data. Although the data could be "used against them" it could also display a real picture of the existing health care system.

The public process of examining limited health care resources in order to reduce excess supply and reduce duplication of health care resources was never thought to be a painless process. If an agency has performed a thorough evaluation of the need in the health service area and assessed the resources to accomplish the community's objectives (objectives developed through an open process wherein members of the community, including providers, are invited to participate) it has a responsibility to the public to recommend changes necessary to improve the system in their area.

Question: What authority do health planners have under the law to enforce any conclusions that certain health facilities are not needed?

Answer: None. For the most part, compliance with planning agency decisions is voluntary, unless a State enacts sanctions which link to appropriateness review. However, institutions whose services are deemed inappropriate, through a public process, may come under community pressure to make the changes recommended by planning agencies.

THREAT TO COMPETITION

Question: To what extent does the health planning program act to thwart competition in the health industry?

Answer: The 1979 amendments to the health planning legislation sought to encourage competition wherever market forces promote price competition, quality care and the availability of necessary services. The following language added to section 1502(b) of the PHS Act illustrates this point:

> (1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health ser-

vices and facilities, particularly in the case of inpatient health services.

(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this title take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this title) to allocate the supply of such services.

(3) For the health services for which competition appropriately allocates supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this title give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access) to actions which would strengthen the effect of competition on the supply of such services.

In addition, Congress added as a National Priority for the health planning program: "The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve in accordance with subsection (b), to advance the purposes of quality assurance, cost effectiveness, and access" (section 1502(a)(17)).

As a specific example of a pro-competitive activity, the health planning law mandates that each health systems agency collect, analyze, and publish data on charges for the 25 most frequently used institutional health services (new section 1513(h)).

The Bureau of Health Planning has begun to implement these sections by making planning agencies aware of how market forces work to stimulate competition in some areas of the health care industry. Technical assistance materials have been provided to all the agencies, and training sessions have been held in all parts of the country for planning agency staff and board members on the subject of competition.

Question: Would competition occur in the absence of the health planning program, and if so, what sort of competition-cost-effective or cost-inflating?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What areas of medical care appear to offer the best prospect for the success of competition? How have HSAs encouraged this type of competition?

Answer: Competition occurs among various levels of medical care (e.g., long-term care, ambulatory care, etc.) and among payments mechanisms (prepayment, such as HMOs, indemnity, and self insurance). It ordinarily does not occur, for example, between hospitals, at least on the basis of price. Most people choose their physicians, and the latter choose hospitals (on the basis of factors other than cost).

An example of where competition may be effective is in health maintenance organizations (HMOs). They provide the full spectrum of service including outpatient surgery, inpatient services and routine preventive maintenance health care. In many communties HMOs have been able to compete on price with the existing fee-for-service system.

HSAs provide a forum for deciding what course of action is best for their local area. In some communities increased competition might be in the best interest of society, but other communities may decide that increased competition will work to their disadvantage. For example, HMOs should only be encouraged where there is sufficient support. Communities should take into consideration their size, local politics, and the medical resources available before making decision. As HSA can play a major role in encouraging competition by promoting the development of HMOs where appropriate.

There are certain elements that must exist in the market place for competition to occur. Consumer knowledge concerning the product and the price of the product are necessary elements. Also the price differences must actually make a difference to the consumer (if third party payments cover all costs, with deductible and no co-payment, the consumer will ignore price differences). HSAs have strengthened the consumer knowledge aspect of the health care market economy with actions such as those described below.

- Developing consumer guides to medical and physician services. Physician directories, lists of physicians accepting assignment, and publication of physician fees are examples of this.
- Developing consumer shopping guides for health insurance plans.
- In the case of institutional services where consumer choice is limited by provider affiliation, HSAs provide information concerning size, breadth of services available, charges for accommodations and services and staff makeup.
- Organization of coalitions of consumers (and providers) which have as their goal the education and general awareness of the full rang of options for obtaining health care.
- Work with the business community and other major purchasers of health care to work to determine how reimbursement mechanisms can foster competition.

This knowledge can be used not only in personal decision-making but also in making decisions about the system of health care which should be in place in the community.

Question: Would some form of health planning take place at the local and State level in the absence of Federal support?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

PROPOSED USE OF FEDERAL FUNDS

Question: As I understand it, the review of proposed uses of Federal funds at the local level essentially enables an HSA to stop Health Service Projects which are funded directly by federal agencies from entering a community if such projects are deemed as not needed. Can you explain what incentive an HSA would have for turning down a project grant when:

- Presumably, Federal officials have determined a need exists based on the need determination requirements of individual grant programs
- State and Local Community Political Leaders see bringing in federal projects and funds as enhancing their prestige, and
- No benefits seem to be derived from turning down a project?

Answer: Fequently health systems agencies (HSAs) do not have an incentive for turning down a project grant because, as agents of their communities, they have worked with State and Federal governments to stimulate applications. In order to implement their plans HSA staff often assist community groups with the cumbersome Federal application process. The subsequent review of the proposal by the community Board of the HSA serves as a validation that the applicant proposes to provide a program consistent with the local plan.

In addition, there are incentives for HSAs to disapprove project grants. Many Federal need determinations are mechanical formulae which do not account for changes in the local medical service area. A project may be consistent with Federal need determinations yet be based on obselete data or propose a clinic site in an inconvenient or inaccessible location. Based upon experience to date, State and local political leaders are often as vocal in their opposition to a specific project grant proposal as they are in support of the intent of the Federal program. In reviewing Federal funds HSAs have to take into account the views of local leaders when supporting or turning down an application.

PLANNING - COST CONTAINMENT PROGRAM

Question: The budget now before Congress proposed a cost-cutting plan to reduce hospital beds and improve coordination with State Rate Review programs.

To what extent would it be possible for you to initiate such a program with only a portion or without the additional $13 million you seek for State planning agencies?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: To what degree have you considered initiating this as a limited demonstration program?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

PLAN DEVELOPMENT AND IMPLEMENTATION

Question: In your judgement, if you were a local official with a limited budget responsible for developing and improving the health services available in a community, to what extent would the typical health systems plan be helpful to you?

Answer: The purpose of a health plan is to identify the existing health status and health systems problems in a community, describe desired changes, and delineate the activities to move the community in the direction of those changes, and the resources needed to do so.

A local official would use the plan in helping him or her decide the wisest ways to use scarce resources. When controversial matters arise, local officials will be able to use information in the plan to assist them in developing their position. Knowledge of how the community perceives its problems, and the priority it places on them would be very beneficial to public officials. For example, the HSP should help in deciding whether or not hospital expansion is desirable. If so, which hospital should expand and why. The estimated cost should be in the HSP along with possible financing mechanisms. Local officials will be able to better anticipate and plan for related activities such as issuance of revenue bonds or increased taxation. As a result of reading an HSP, the local officials will be better informed of the communities served in making decisions and expressing policy. As local budgets have become constrained by inflation, the local planning agencies would become important supplemental sources of intelligence to assist local decisionmaking.

Question: What evidence can you present to show that health planning has been effective in holding down local health costs?

Answer: In 1979 the American Health Planning Association conducted a study which determined the health planning agencies disapproved or discouraged $3.4 billion in capital investment projects during the period from August 1976 to August 1978. The estimate of this study is that these agencies saved the health care system $8 for each $1 spent on the program.

While the General Accounting Office has discounted only some of these figures, the evidence clearly shows that the health planning system has prevented a considerable amount of unnecessary capital expenditure. Health planning agencies have documented that proposals for capital expenditures are frequently withdrawn from consideration or modified to drastically reduce costs. We do not have complete information on the amounts of these withdrawals and modifications, but from July 1979 to June 1980 the estimated amount was $200 million.

A case can be made that the State CON programs mandated by the Health Planning Act have had some positive effect in reducing or moderating unnecessary capital expenditures by hospitals and other health care facilities in recent years. For example:

- Based on data reported by HRA, roughly $450 million in proposed capital expenditures were denied by State agencies during a recent 12 month period (7/1/79-6/30/80).
- Four hundred fifty (450) of 3,411 hospitals surveyed by the AHA in late 1979 reported that they had postponed or dropped plans for expansion of their facilities or services. The

principal reason cited by these hospitals themselves was the requirement for a certificate of need.

- A recent study by Dr. Julianne R. Howell of the University of California/San diego, Regulatory Hospital Investment: The Experience in Massachusetts concluded that capital expenditure reviews have helped to limit hospital capital investments and reduce duplication of facilities. Over the period 1972-1976, one-fourth of all the projects by a sample of Massachusetts hospitals for a certificate of need were either denied or significantly modified through review.

PLANNING METHODS DEVELOPMENT

Question: You presently have four Centers for Health Planning to, amoung other matters, provide technical assistance to health planning.

Why should the Federal Government continue to support these Centers? Can't the Health Systems Agencies develop their own means of technical assistance if they deem it necessary?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: How do you know whether these Centers are effective? What measures do you use?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

STUDENT ASSISTANCE

Question: What is the current situation regarding payback of Health Professions Student Loans?

Answer: Health Professions Student Loans are returnable to the Federal Government by the lending schools not later than December 31, 1983. Thereafter, the schools are required to return not less often than quarterly those student loan funds collected.

The student borrower has a grace period and rights to deferment status before his/her ten year repayment schedule goes into effect. The health professions schools can only require repayment of student loan funds as they fall due.

Question: Is there a big default problem?

Answer: There is not a big default problem.

Graduate and non graduate health professions students are in a position to compete in the job market for salaries sufficient to pay their loan obligations.

Question: What thought has been given to requiring loan defaulters to incur some form of service obligation, such as military service?

Answer: Suggestions for methods of getting loan repayments back in line would be 1) to allow a search by Social Security Number through IRS and subject tax refunds to suspension or withholding until delinquent loans are paid back or brought up to date, 2) to permit loan programs to contact credit bureaus and affect credit ratings accordingly, and 3) to permit a search of government payroll as well as medicaid and medicare payees to find defaulters.

For the government to require service obligation such as military service, would probably be subject to more legal challenges than worthwhile. Active and vigorous prosecution of defaulters would probably be the best solution, however, this would call for a larger staff for the PHS Claims Office, and would still be subject to long delays associated with anything carried into the court system.

DUPLICATION AND IMPLEMENTATION

Question: Since HSA's have no authority or resources to implement their plans and are essentially outside the political structure of a community, what can we realistically expect in the way of implementation?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: If we can't expect much in the way of implementation, haven't we cast a great deal of doubt on the value of developing the plans?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HOSPITAL "FREE CARE"

Question: How extensive is compliance with this provision, now that the Federal Government is responsible for enforcement as opposed to the States?

Answer: A triennial reporting system is being implemented during FY 81 whereby 650 facilities will report data to demonstrate their compliance with the regulations. The remaining facilities will report in FY 1982, and 1983. We will be able to assess overall compliance when the completed reports are received and analyzed. The first overall analysis is planned for the end of FY 1981.

Question: Is there any overlap between the people who uncompensated services under this provision and persons covered by Medicaid? If so, does this mean that a hospital doesn't charge Medicaid for the services provided to the indigent eligible for Hill-Burton "free care?"

Answer: The assurances regulations do not permit a facility to "count" as uncompensated services any care which could or would be provided to persons qualified as Medicaid recipients. As the program of "last resort" Hill-Burton assistance can only be provided to Medicaid beneficiaries when Medicaid benefits end. An individual's eligibility for "free care" is based on the Community Services Administration Income Poverty Guidelines, applicable nationwide. Conversely, each State establishes its own eligibility requirements under the Medicaid program.

Question: What is the total amount of so-called "free care" provided by hospitals and other health facilities with a Hill-Burton obligation and how many patients benefit?

Answer: It is estimated that $500 million dollars of uncompensated services will be provided annually for the next several years. Since each facility can choose which of its services are available as uncompensated services (i.e., emergency room, burn unit), the number of patients who benefit will vary widely from hospital to hospital from year to year. The triennial reports mentioned in the answer to question 2 will provide raw data from which estimates can be made.

HEALTH TEACHING FACILITIES: SUBSIDIES

Question: We note you are requesting additional funds in FY '82 to pay some $2 million in connection with a defaulted loan.

What is involved in this situation and how much more will be required from the Federal Government?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

MEDCIAL FACILITIES GUARANTEE AND LOAN FUND

Question: Why is it necessary to request an appropriation of $35 million for this account when unboligated balances plus anticipated loan repayments are more than enough to meet the cost of required interest subsidy payments?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: How long will it be necessary to make interest subsidy payments under this program?

Answer: This matter is currently under review by Secretary Schweiker. Once the New Administration's policy has been established, it will be provided to the Subcommittee.

NURSE TRAINING - IOM STUDY

Question: What is the status of the Institue of Medicine (IOM) Study of problems in the nursing profession? Is there an interim report we can look at?

Answer: The Institute of Medicine's study of nursing and nursing education is now in Phase I of the 3-phase, 2-year effort. Preliminary advance work on the study actually began in March 1980, when the Department provided funding to IOM for development of an overall study plan. The study plan was completed and submitted to HRA in September 1980, and final agreement on the full 2-year study was reached between IOM and HRA on January 12, 1981. Although serveral technical Reports--on data collection needs and a detailed specific design plan--are called for during the early months of Phase I of the study, the mandated 6-month interim Report to Congress is not scheduled to be completed until June 1981.

ADVANCED TRAINING/PROFESSIONAL TRAINEESHIPS

Question: How may individuals would be denied professional traineeships if this rescission or deferral were approved?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: What kinds of programs are supported by Advanced Nurse Training? How many programs focus on health problems of the elderly?

Answer: The Advanced Nurse Training Program offers graduate preparation in nursing education, nursing service administration, and in six clinical areas--gerontological nursing, maternal-child health nursing, community health nursing, medical-surgical nursing, adult health nursing, and acute care nursing. Some 83 such projects are currently supported, including 19 master's level programs that provide specialized preparation for the care of the elderly. These specialized programs which focus on the elderly are all relatively new and are using the Advanced Nurse Training funds to strengthen their programs and prove the viability of these efforts to the State legislatures that will eventually provide ongoing support.

Question: As you probably know, directors of nursing in hospitals ofter handle budgets that reach into the millions of dollars. How do you characterize the type of educational backgrounds that these people generally have and do you believe that their training is adequate?

Answer: As of 1977, an estimate 4.9% of all registered nurses in the United States were employed as nursing administrators. Of these, 65% held less than a baccalaureate degree, 15% held the baccalaureate degree, and 20% held a master's or higher degree.

This is in sharp contrast to the requirements recommended by the Panel of Expert Consultants for Improved Distribution of Nursing Personnel and Services (WICHE, 1978) who recommended 95% with master's preparation and %5 with doctoral preparation for top level administration in all settings. Recommendation for mid-level administrators was for 25% with master's preparation and 75% with baccalaureate level preparation.

The Advanced Nurse Training Program has particular authority to reverse this shortage through the support of graduate level programs in administration and through contract efforts, three of which have developed model programs to prepare top level administrators.

Question: The Administration's justifications previously submitted for the rescission request on the Advanced Nurse Training program indicates that the impact of the rescission would be the elimination of 50 new projects and 23 continuations. I'm particuarly concerned about these continuations. How does this impact on program continuity if you are eliminating these institutional-based projects in mid-stream? Is this fair and equitable?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

NURSING SCHOOL CAPITATION

Question: Has the nursing school capitation program been successful in stimulating nursing school enrollments?

Answer: Yes. The nursing school capitaiton program has stimulated nursing school enrollments as well as the devlopment of new schools of nursing.

As reflected in the following chart, total enrollments in participating schools increased from 161,292 in 1973 to a peak of 206,347 in 1978' an increase of 191 participating schools and 45,055 full-time student enrollments. In 1979 and 1980, both the number of schools and the number of full-time students enrolled declined somewhat due to inflationary and economic factors resulting in increased numbers of students enrolling for part-time rather than full-time study.

In the years since 1972 when the first capitation grants were awarded to nursing schools, more than 400 new associate degree and baccalaureate programs in nursing education were developed and participated in the capitaiton grant programs, of which 256 were AD programs and 188 were Baccalaureate programs. Numbers of Diploma programs declined from 263 in 1972 to 135 on 1980. Approximatley one-third of the new Baccalaureate programs established in recent years are upward mobility programs geared to advance associate degree and diploma graduates to the baccalaureate degree.

Enrollments (by type of program) in schools participating in the Nursing Capitation Grant Program 1973-1980

	Total-All Schools		Diploma		Assoc. Degree		Baccalaureate	
	No. of Schools	Total Enrollment	No. of Schools	Total Enrollment	No. of Schools	Total Enrollment	No. of Schools	Total Enrollment
1973	890	161,292	209	35,133	408	52,091	273	72,068
1974	917	177,351	181	31,723	445	60,310	291	85,318
1975	1,050	194,873	171	29,727	485	68,204	322	96,942
1976	1.012	194,660	176	30,166	505	71,473	331	93,021
1977	1,055	199,615	168	28,519	522	72,630	365	98,466
1978	1,081	206,347	165	28,189	545	75,730	371	102,428
1979	990	183,374	116	19,030	509	69,534	366	94,810
1980	1,075	190,516	135	20,616	554	74,724	386	95,176

Question: What percentage of the average nursing school's operation budget can be attributed to the capitation gran program? How will school's make up for the shortfall?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: What types of nursing schools would be most severely impacted if this rescission or deferral were approved?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: How many schools would be affected overall, and how many students would be involved if the nursing shcool capitaition rescission or deferral were approved?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer the is question.

NURSING PROGRAMS

Question: Even though the number of nurses per 100,000 population has increased over the years, the nursing professions argues that changing medical technology and medical practices requires more intensive nursing care than what was required 10 or 20 years ago. To what extent did you take these factors into account in assessing the number of nurses that will be needed?

Answer: These factors were considered in arriving at the conclusion that supply and requirements would be roughly in balance. However, data on which this conclusion was based indicated that shortages might continue to exist in certain settings such as those in which acutely ill patients receive care. And we will be re-evaluating whole issues of adequacy of supply of bedside nurses.

CAPITATION

Question: To what extent are the States increasing their funding of medical schools?

Answer: State support to public and private schools of medicine in total, increased 201 percent form 1972-1973 to 1978-1979, from $359 million ot $1,080 million.

The support to public schools of medicine, 1972-1973 to 1978-1979 increased from $313 million to $1 billion or 19 percent and support to private schools fo medicine during this same period increased from $46 to $79 million or 71 percent.

In 1972 constant dollars, State support to public medical schools. 1972-1973 to 1978-1979 increased 197 percent, from $313 to $667 million, and State support to private medical schools increased 13 percent from $46 to $52 million.

However, in the more recent period, 1975-1976 to 1978-1979, State support to public schools, in current dollars, increased 55 percent, and in 1972 constant dollars, 31 percent. During this same period State support to private schools of medicine, in current dollars, decreased 3 percent and in 1972 constant dollars, decreased 23 percent.

Note: The Association of American Medical Colleges reported that between FY 1973 and FY 1976, aggregate State funds for medical schools increased by approximately 77 percent and the mean grant per student increased by nearly 70 percent.

Quesiton: Among other reasons, Congress authorized capitation support to assure the financial stability of health professions schools. With significantly decreasing levels of Federal funding for catitation grants, why does any funding need to be continued for purposes assuring the financial solvency of schools?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: Aside from State support, what other sources of financial assistance are available for health professions schools to draw on for their education programs?

Answer: The prinicipal resources which have been available to these schools are: Federal grants and contracts for research, teaching, and institutional support, endowments, private foundations/ philanthrophy investments and tuition.

FINANCIAL DISTRESS GRANTS (MEHARRY)

Question: In approving a reprogramming of funds late last year to assist Meharry, the Committee said you should not disburse any money unless the school's requests are well-justified. What have you done about this?

Answer: The FY 1981 Financial Distress Grant to Meharry contains conditions on disbursement of the funds which are designed to ensure well justified budget requests. Specifically these conditions require that:

1. None of these funds may be used for the purchase or lease of capital equipment.
2. Payment of the funds for this grant shall be based on the approved budget and monthly expenditure plan.

Question: What are you doing to bring about financial and managerial reforms at Meharry?

Answer: The Department has initiated action in several areas designed to assist and stimulate Meharry to make needed reforms and achieve financial stability. These actions include:

1. The implementation of a management agreement between Meharry and the Department which requires Federal review

of: staffing of Key management positions, the College's annual operating budget and other activities to maintain proper stewardship of Federal funds and to aid in improving management operations.

2. Funds in the FY 1980 financial distress grant specifically provided for:

   a. Contract to set up a new accounting system
   b. Contract to establish a model plan to accurately project income and expenses for Meharry and
   c. Contract to implement needed changes recommended by management studies.

In addition, the Under Secretary and the Assistant Secretary for Health had met with top officials of several national foundations, such as MacArthur and the Robert Wood Johnson Foundations, to review the need at Meharry to support management reforms and for upgrading academic and research programs. The Department has also explored the possibility of obtaining greater support from the Tennessee State Government, the Southern Regional Educational Board and the city of Nashville.

Question: What is Meharry doing outside its management contract with the U.S. to solve its financial and managerial problems?

Answer: Meharry has taken a number of actions designed to improve its management, reduce expenditures, and increase income. In its effort to improve management, Meharry has followed most of the recommendations of study groups but has had difficulty in finding adequate resources to fully implement needed reforms. The school has recently changed its top leadership and is actively recruiting key senior level managers. This recruitment effort is being supported by funds from the MacArthur Foundation.

Expenditure reduction over the past several years has been accomplished by cutting back administrative and operating expenses while attempting to support the necessary academic base to maintain accreditation. The school has contracted out the management of its hospital to the Hospital Corporation of America which has undertaken reducing operating costs and improving the patient census at the hospital.

Income increases over the past few years at Meharry have come largely from Federal grants and contracts, support from the Southern Regional Education Board and raising tuition. Currently, the school has initiated a fund-raising campaign, has generated support from foundations and has received a large pledge of funding from its Alumni Association. Meharry is also exploring obtaining funds from states whose citizens are students at Meharry. The College has been successful in this effort and is receiving Capitation funding from several states, including New York. Meharry is seeking to obtain similar funding from other states.

DENTAL TEAM PRACTICE

Question: Why is this program needed at all?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What benefit does it provide the dentist and the patient?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

PUBLIC HEALTH SCHOOLS

Question: What evidence is there that there would be a serious shortage of public health professionals if this program were to be terminated?

Answer: According to the Report to Congress on Public and Community Health Personnel more than double the current number of epidemiologists is needed and shortages exist in the number of statisticians, public health nutritionists, certain categories of environmental health practitioners, and preventive medicine physicians. The predominant fact is that requirements for training are now being generated by shortages of requisite knowledge and skill even more than by measurable numerical shortages. Examples include: the dearth of epidemiologist trained to deal with chronic diseases, the behavioral disorders and environmental health issures; and the lack of environmental personnel prepared in the chemical (chemical waste, toxicology) and the physical agent arenas (radiological health, noise, etc.). Further, though there are indications more health services administrators are being graduated than the market demands, particularly for hospitals, shortages in specialty areas (financial management, health economics, etc.) and special settings (HMO, Multi Hospital Systems, Long Term Care) continue to exist.

Without the support provided through this program, institutions, particularly the 22 schools of public health, would have serious difficulty in maintaining or expanding graduate programs in these high priority areas.

Question: Since the Federal Government ordinarily does not need to remedy shortages in other professional fields such as engineering or computer sciences, what is the rationale for a Federal responsibility in the field of public health?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

PUBLIC HEALTH SPECIAL PROJECTS

Question: According to your budget justification you are planning interaction between schools of public health and employees of the Center for Disease Control (CDC) and the Health Resources Administration (HRA).

Please explain how this will work.

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: Will the federal employees have to go to the schools to interact--or will the students and faculty come to them?

Answer: This matter is currently under review by Secretary Schweiker Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: If CDC and HRA are to provide special instructional materials to the Public Health Schools, to what extent will the Federal Government be reimbursed for this?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

FAMILY MEDICINE RESIDENCIES AND TRAINING

Question: Why does the budget estimate for this program envision a reduction of approximately 1600 positions to be supported in fiscal year 1982?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: Why does the average cost per intern/resident in the graduate program increase by 21% in 1982 compared to 1981?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

AREA HEALTH EDUCATION CENTERS

Question: Under the 10-year funding assumptions contained in Title VII, when will Federal funding for this program terminate?

Answer: It is assumed that the reference is to the nine years of funding generally provided in Title VII. Under this provision, the AHEC's funded Section 802 (orginally funded in 1972) have received their final Federal support from FY 1981 funds with activities terminating, in most instances, on September 30, 1981. The 11 AHEC's funded under Section 781 received their original funding in different fiscal years (1977, 1978, 1979), and thus are in different stages of development. In addition, the period of funding projected depends on the stage of developmemt of the project when Federal support starts, the number of centers and the number of cooperating medical schools involved. No center may receive funding for longer than six years. Termination of the projects varies from FY 1982 to FY 1987. The last of the ongoing projects will require final Federal support in FY 1987. Should new projects be funded in the future, the program would need to continue for a longer period.

Question: What is the feasibility of accelerating the 10-year schedule for the remaining projects?

Answer: Public Health Service program approach provides for three stages in the development of an AHEC - planning (1 year), development (1 year), and operational (4 years). Thus, a maximum of six years of funding is provided for any one center. In addition, the Federal support is decreased and cost share is increased beginning in the fifth year; the sixth year provides for further decrease in Federal support and increase in cost share by the program. In statewide projects, involving multiple schools and multiple centers, projects phase-in their activities. Centers may be planned through the fourth year and receive funding through the ninth year of the project (three years after termination of funding for the centers planned in the first year).

Acceleration of the existing schedule does seem feasible as a mechanism for promoting earlier phase-in of alternative funding sources for future projects. However, this is not a reasonable mechanism for consideration with respect to ongoing projects.

Complex relationships have been developed between the medical schools and the community-based centers, as a result of serious commitments on both sides. To disrupt the current aggreements/ understanding would seriously jeopardize previous programmatic gains.

EMERGENCY MEDICAL TRAINING

Question: The budget narrative indicates that you are terminating the Emergency Medical Training program on the grounds that it is a local responsibility. At the same time, the Health Services Administration is continuing the Emergency Medical Services grant program.

If grants for emergency medical services are a Federal responsibility, why isn't it also a Federal responsibility to provide for the training fo the personnel needed to carry out the service?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

ALLIED HEALTH PROGRAM

Question: The 1982 budget indicates that no funds are being requested for the Allied Health program on the grounds that local community colleges and state universities are responding to the increased demand for allied health professionals by creating new programs and classes.

What is the total enrollment in such programs and how much has enrollment increased over the last two years?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HEALTH PROFESSIONS EDUCATION IMPROVEMENTS AND DEVELOPMENT PROJECTS

Question: What indications do you have that medical schools will continue to support the training projects funded by this program, especially in such areas as nutrition, geriatrics, and environmental health?

Answer: We do not have any solid evidence that medical schools will continue these programs. However, it must be emphasized that these were curriculum development projects, and some elements have become institutionalized. Much of the instructional materials which have been produced can continue to be used and refined.

Question: What is the status of the 80 projects in such areas as humanistic medicine and geriatrics that are funded under "Educational Improvements?"

If funds are rescinded or deferred, what will happen to these programs?

Answer: Twenty-seven environmental health projects would not be funded. Thirteen of these would be in their last year of Federal support. Fourteen of these projects would be terminated after one year of planning and development. All twenty-one of the geriatric projects are in their third and final year of Federal support. The rescission would terminate the third year of funding for these twenty-one projects.

In fiscal year 1980, 13 grants in humanistic health care were awarded totaling $922,484 their first year of funding. A rescission or deferral action will eliminate the second and third year funding for the humanistic health care projects.

Hospice activities funded include the development of a training manual for interdisciplinary team training and humanistic patient care training of hospice staff. This contract activity was awarded in 1979 and is scheduled for completion September 1981.

Thirteen applied nutrition grants were funded in FY 1980 at $1,512,322. The third and final year for these grants is expected to be funded at $1,499,460 in FY 1981. Two new projects were planned for funding in FY 1981. Rescission or deferral of funds from this program will eliminate the funding of these nutrition projects in 1981. It is possible that institutions may restore the funding of some of these projects.

HEALTH PROFESSIONS ANALYTICAL STUDIES

Question: In view of the constraints on the budget, why do we need further analytical studies and reports on the supply of health professionals? Can't we get this information from groups such as the American Medical Association?

Answer: The analytical program serves a wide range of specific important functions. It continually monitors changes in the supply, distribution, and utilization of health professions, and it looks into the future to assess the long-range implications of these changes. It analyzes the geographic distribution of health professionals and the reasons for the distribution, and examines the changes in distribution that are regularly occurring, with particular emphasis on how the market mechanism is working to distribute personnel. It also designates Health Professions Shortage Areas to support National Health Service Corps placements and other programs, and work closely with States and local areas to identify maldistribution and its alleviation. Finally, it conducts basic analysis of the supply of and requirements for health professions and the factors affecting changes in the numbers and distribution of health professionals and in their delivery of care, with particular emphasis placed on forecasting future supply and requirements under varying assumptions. In short, the program provides a distant early warning system as to changes in the professions and in care delivery, provides a monitoring and assessment of the status of the professions and develops the information on the causes of change in the professions needed for the design of sound, efficient programs.

While the professional associations are an important source of data for analysis and several even maintain their own analytic programs, the associations do not have the staff, resources or interest in providing the information developed by the Analytic Studies and Reports program for this wide range of purposes.

Question: Why can't the studies funded under this program all be done in-house by the permanent staff of HRA?

Answer: Traditionally, the largest proportion of the work undertaken in the Analytic Studies and Report program has been done in-house by the Agency's staff of statisticians, economists, and health analysts. The contract funds have been employed to complement and supplement the in-house activities by providing data, data bases, and basic research studies that serve as input into the focused efforts of the analytical program. Since the program deals with such a variety of issues and topics (covering such diverse areas as educationalinstitutions, students, costs of education, health personnel, geographic distribution, health care institutions, and health care delivery settings and reimbursement), it is essential that some contract funds be available to fill analytical gaps and to make the most efficient use of the in-house staff.

There are also several specific reasons why it would be infeasible and cost-intensive to attempt to do all the work internally. One is that a number of studies needed require types of expertise specific to a particular study or staffing which varies significantly from month to month, and it would not be feasible to staff specifically for such studies through permanent staff, especially given Federal personnel procedures and ceilings.

Another problem is that when a particular expertise is needed, it is often difficult or effectively impossible to recruit suitable staff, especially for relatively short periods of time or quickly. Even if staffing difficulties could be overcome, the internal staff is numerically insufficient to do all the studies required. Contract funds support approximately 55 to 60 man-years of effort, which now actually equals or exceeds the in-house staffing of the program. Since mandated or basic program activities such as the designation of shortage areas, the preparation of reports and studies for the Secretary, the Congress, the development of forecasting models, and the monitoring of health professions developments require much of the efforts of the internal staff, a reduction in contract funds without commensurate increases in staffing at the program level would severely hinder the new analyses directed toward improving and expanding information on the more than 5 million health workers in dozens of occupations. A further reduction or elimination of contract funds would thus pose serious problems because it is this continued development of better information which underlies improvements in the effectiveness and efficiency of new programs and policies.

IMPACT OF REDUCTION IN HEALTH PROFESSIONS EDUCATION

Question: President Reagan is proposing to cut the budget for Health Professions Education to $120 million in 1982 compared to a level of $169 million in the Carter budget and $343 million in 1980.

Where will these reductions be taken?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: What impact will these reductions have on the availability of health professionals in areas where they are needed?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established it will be provided to the Subcommittee.

PHYSICIAN ASSISTANTS

Question: What percentage of the total cost of training a physician assistant is provided by the Federal Government and what percentage is paid for by the trainee?

Answer: Data on the Federal constribution to the total cost of training a physician assistant are not available. However, the Federal Government is supporting 75% of all physician assistant programs approved by the American Medical Association (AMA). It is estimated that the range of Federal support is from 50% to 90% of total cost of a program with the majority of situtations being more than 50% of total cost.

Question: What evidence is there that the number of people entering the physician assistants field would be reduced if Federal aid were to be withdrawn?

Answer: The program Division has some data on individual projects that show when funds requested are not provided, the number of trainees involved decreases.

Question: In light of the favorable reports on the work of physicians assistants by the Congressional Budget Office and others, why does the Carter budget proposed a $1.8 million cut in this program?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: Don't physicians assistants help solve the problem of geographical maldistribution of medical care?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

START-UP ASSISTANCE

Question: If the $1.7 million currently available for Start-up Assistance is not rescinded, as the Carter budget requests, what will you do with this money?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

GENERAL DENTISTRY RESIDENCIES TRAINING

Question: The 1982 budget indicates that no funds are being requested for this program in order to direct funds to "other high priority areas."

Why is this program deemed to have a lower priority?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

FAMILY MEDICINE DEPARTMENTS

Question: The budget justification indicates that in 1982, 39 out of the 140 medical schools will receive Federal financial support to establish family medicine departments. How many of the remaining 101 medical schools have established family medicine programs without Federal aid?

Answer: There are 126 allopathic schools and 14 schools of osteopathic medicine. The 126 medical schools, including 10 clinical branches (totalling 136), have the following family medicine department breakdown:

Family Medicine Depts...............	101	
Family Medicine Divisions............	12	
Div./Depts. under development.......	2	Source AAFP 1980
No plans known......................	14	
Others..............................	7	
	136	

Only 40 of these schools have received support under Section 780 to establish and make their departments comparable to other primary care specialties in terms of curriculum, full-time faculty, etc., as the law requires. Thus, a variety of administrative units exist but they may not be comparable to other similar specialties in terms of faculty, curriculum, and other resources.

Question: What are the criteria for providing assistance to the 39 schools indicated in the budget?

Answer: Approval of any application is based on an analysis of the following factors:

1. The potential effectiveness of the proposed project in carrying out the activities of Section 780 of the PHS Act;

2. The extent of responsiveness to the project requirements, guidelines, and application requirements;

3. The administrative and management capability of the applicant to carry out the proposed project in cost-effective manner;

4. The qualifications of the proposed staff and faculty of the unit; and

5. The potential of the project to continue on a self-sustaining basis after the period of grant support.

PRIMARY CARE - GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS

Question: Why do the number of residents supported by this program decline from 1,579 in 1981 to 944 in 1982?

Answer: The support level for this and other health professions programs for FY 1982 is still under consideration by the Secretary, DHHS. Discussions continue between the Department and OMB at this time. We anticipate that information relative to the support of these programs will be available in a few weeks.

Question: Why is the cost per resident nearly double the amount budgeted in the Family Medicine Residencies and Training Program?

Answer: It is difficult to provide a precise response to this question. Both programs (family medicine and general internal medicine and pediatrics) are funded based on providing "the last dollar" to ensure the capacity building desired. However, a number of factors contribute to variations in Federal contribution to the two programs. The assumption is that the reference is to Federal contribution rather than the cost per resident in general. Basically, this response addresses three basic reasons for the difference: (1) the early developmental stage of general internal medicine and general pediatrics programs in relationship to family medicine; (2) the limited funds that general internal medicine and general pediatrics can recover from other sources; and (3) the financial position of medical schools and universities in comparison to some community hospitals. General internal medicine and general pediatrics is fairly new and most of the programs have started with the Federal programs in FY 1977. The Division's internal analysis indicates that the total cost per resident is about the same. However, with the relatively short existence of these training programs in general internal medicine and general pediatrics, the proportion of the total costs per resident provided by the Federal government is greater. Moreover, it appears that general internal medicine and general pediatric programs are unable to recover as much costs from other sources as family medicine. For example, because of their longer existence, some family medicine programs have line item State appropriations. Finally, the financial position of medical schools and university hospitals in the primary care areas may negatively impact on their monetary resources. Eligible grant recipients for general internal medicine and general pediatrics are restricted to medical schools.

Academic Year 1981-81

(Utah)

PROGRAM	SCHOOL	AMOUNT AWARDED
Health Professions Student Loan	University of Utah (Medicine)	$ 57,563
	University of Utah (Pharmacy)	45,482
		$103,045
Exceptional Financial Need Scholarship	University of Utah (Medicne)	$ 38,550
Nursing Scholarship	Weber State College (Associate)	$ 15,137
	University of Utah (Baccalaureate)	12,171
	Westminster College (Baccalaureate)	2,852
	University of Utah (Gradute)	7,302
		$ 37,462
Nursing Student Loan	Weber State College (Associate)	$ 31,753
	University of Utah (Baccalaureate)	20,000
	Westminster College (Baccalaureate)	5,983
	University of Utah (Graduate)	4,300
		$ 62,036

GRAND TOTAL: $241,093

Question: When can Federal financial assistance be phased out for this program?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

HEALTH PROFESSIONS PROGRAM SUPPORT

Question: Total obligations for health education grants are projected to decline from $81.8 million in 1980 to $22.4 million in 1982, a decrease of 73%. However, the number of positions in program support declines for 413 in 1980 to 309 in 1982, a decrease of only 25%.

Why isn't the decline in the number of support personnel commensurate with the decline in program dollars?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

NURSING - REAGAN BUDGET

Question: The Administration's budget proposals call for support for non-physician training where shortages persist. Nursing is mentioned as being in this category.

We all are aware of shortages of trained nurses, but some numbers we received indicate you plan a $54 million cut in nurse training programs in this fiscal year. How does this square with the Administration's claimed concern for nurse shortages?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: Do you propose a fiscal 1982 cut in nurse training that would be some $67 million below the 1981 Continuing Resolution level?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

HEALTH SYSTEMS AGENCIES

Question: Obviously, the health planning system has multiple goals which are not always compatible. Maybe this will prove to be their undoing. Suppose the planning system is eliminated, as President Reagan wants, what would be the effect in a typical planning area? Have the HSAs imposed an order that would not be there without them or that will disintegrate if they disappear? Would cost be likely to rise?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

DISADVANTAGED ASSISTANCE

Question: A recent study shows that the percentage of total minority enrollment in medical schools supported by grants under the Disadvantaged Assistance Program increased from 4.2% in 1972 to 8.5% in 1979 compared to an increase of 4.3% to 5.9% in non-supported schools.

What was the total enrollment in supported and non-supported medical schools in 1979?

Answer: In the academic year '70-'80, 34,676 students attended non-HCOP supported medical schools of which 1,945 or 5.6 percent were minority students. During this same period 28,067 students attended HCOP supported medical schools of which 2,297 of 8.2 percent were minority students. (Data Source: Assocation of Americal Medical College, unpublished data, February, 1981).

Question: Assuming all of the higher minority enrollments at the supported schools are a result of the program, what is the cost per additional student enrolled in medical school?

Answer: The complexity of estimating per pupil per-enrollment costs associated with HCOP must be examined both from an undergraduate as well as graduate health professsions schools perspective.

In FY '70 HCOP funds to undergraduate institutions totaled $3.9 million of 35 projects. These projects provided a range of pre-application activities including academic enrichment for basic skills improvement to advanced chemistry for disadvantaged students with

MODVOPP career aspirations. The cost per pupil in these activities range for $203 to $4198.

On the graduate or health professions level, per-enrollment and retention services represents another dimension of costs for student support. In FY '79 these costs totaled $8.1 million for 74 projects. The cost per pupil ranged from $293 to $5337.

The range in cost per pupil in both the undergraduate as well as graduate health professions schools attests to the diversity of the HCOP supported programs.

Question: Why is it necessary to expand the funding for this program by over 50% for FY 1982?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: In light of reports indicating an oversupply of physicians by 1990, doesn't the Disadvantaged Assistance Program contribute to that oversupply by encouraging people to study medicine? Please explain.

Answer: Although a major concern is to provide opportunity for the disadvantaged to enter medicine, the HCOP Program also addresses opportunities for the disadvantaged in seven other major fields and allied health.

The GMENAC report states that although the number of medical students should be reduced, "care should be taken to assure that programs to increase the representation of minority groups in medicine are not thwarted."

The GMENAC report also recommends that one method of attaining a greater diversity among medical students is the broadening of the characteristics of the applicant pool with respect to socio-economic status, age, sex, and race.

Studies have demonstrated that minority/disadvantaged physicians are more likely to serve minority/disadvantaged population groups and that they are more likely than nonminority/nondisadvantaged physicians to choose urban and rural underserved areas as practice locations. The special health problems of minorities and disadvantaged groups would be exacerbated by any efforts to reduce future provider supply.

Available data indicate that there is no oversupply of minority/disadvantaged physicians and there is no likelihood of a minority/disadvantaged physician/population parity in the foreseeable future.

PROGRAM MANAGEMENT

Question: The three elements of HRA each have a sizable program management staff--272 in Health Planning, 155 in Health Facilities, and 309 in Health Professions, for a total of 736. At the same time, the Office of the Administrator has 208 people to manage the work of three sub-agencies.

Why do you need 208 people to oversee the work being done by 736?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established it will be provided to the Subcommittee.

ADMINISTRATIVE OVERHEAD

Question: Please provide for the record a table showing administrative overhead costs for each program under the jurisdiction of HRA.

Answer: (Based on 1981 available funds under Continuing Resolution P.L. 96-536 thru 6/5/81)

Program	Salaries & Expenses
Health Planning	$10,280,000
Health Facilities	5,153,000
Health Professions	17,012,000
Total	$32,445,000

Note: Table does not include student assistance programs which were transferred to the Health Service Administration.

[CLERK'S NOTE.—The following is the administration's response to those questions in the record that were under review by the Secretary at the time the Department submitted earlier responses.]

CAPITATION

Question: The Graduate Medical Education National Advisory Committee (GMENAC) reports that there will be a surplus of about 70,000 physicians by 1990. In view of this, (projected surplus of physicians) to what extent can funding for medical school capitation grants be justified?

Answer: The Department has sought for a number of years to phase-out capitation support to medical schools and Congress has approved reductions to capitation support the past three years. Support for the Capitation Program was predicated upon the need for increased enrollments and improving the quality of health professions education programs. The program has been successful in meeting its objectives. We believe it has contributed to the point that a sufficient supply or a surplus of physicians will be attained by 1990 and that no further federal incentives are necessary.

Question: Among other reasons, Congress authorized capitation support to assure the financial stability of health professions schools. With significantly decreasing levels of federal funding for capitation grants, why does any funding need to be continued for purposes of assuring the financial solvency of schools?

Answer: Health professions schools have known about the reduction and eventual withdrawal of capitation funds. This transition phase has been occurring for the past three years and is now at a per student level where schools can more easily acquire replacement resources and, therefore, not experience a major shock in the loss of capitation funds. Capitation funds represented a relatively small percentage of the overall health profession schools revenue.

Question: What role does such federal assistance continue to play in health professions education?

Answer: In light of the growing projected supply of most health professionals, the administration feels it is no longer necessary to continue general subsidies for increasing enrollment of physicians and other health professionals. We feel the capitation program has been successful in achieving its objectives. Federal funds will be targeted to the most urgent problems facing the health professions.

FINANCIAL DISTRESS GRANTS (MEHARRY)

Question: What is the status of your continuing support for Meharry Medical College under the Financial Distress Grant Program?

Answer: The FY 1981 Financial Distress Grant Review Cycle, accelerated to permit early fiscal year funding, resulted in a Grant to Meharry of $5,267,000. This amount was increased by $2,600,000 through a reprogramming from Health Professions Capitation and Start-Up funds for a total FY 1981 Grant of $7,867,000 to the college.

Question: We understand that this sort of support could go on for years. What can you tell us about this?

Answer: As part of new legislation to be proposed, no institution can receive financial distress grants for more than three years and no grant can exceed 75% of the grant to that school in the preceding year.

NURSING - REAGAN BUDGET

Question: The Administration's budget proposals call for support for non-physician training where shortages persist. Nursing is mentioned as being in this category. We all are aware of shortages of trained nurses, but some numbers we received indicate you plan a $54 million cut in nurse training programs in this fiscal year. How does this square with the Administration's claimed conern for nurse shortages?

Answer: There are a number of factors beyond the purview of the federal government which contribute to the nursing shortage such as: low salaries, lack of autonomy, "burnout", lack of opportunity for upward mobility, etc. We are refocusing our limited resources on addressing these issues, particularly with respect to increasing the active supply of bedside nurses by continuing funding for nursing special projects and nurse practitioners. In addition, it is expected that the results of the two year study currently being conducted by the Institute of Medicine will assist the Administration in making decisions on how to best focus future Federal funding for nurse training.

Question: Do you propose a Fiscal 1982 cut in Nurse training that would be some $67 million below the 1981 Continuing Resolution level?

Answer: The 1982 President's budget request for Nurse Training is $14,232,000, $68,758,000 less than the 1981 continuing resolution level. Funds are directed to the Nurse Practitioner program which trains nurse practitioners in primary health care, the Advanced Nurse Training program which prepares nurses to be clinical nurse specialists, teachers, administrators, and the Nursing Special Projects program for improving the development and distribution of bedside nurses.

ADVANCED NURSE TRAINING/PROFESSIONAL TRAINEESHIPS

Question: How many individuals would be denied professional traineeships if this rescission or deferral were approved?

Answer: It is estimated that approximately 2,073 individuals would be denied professional nurses traineeships if this rescission was approved.

ADVANCED NURSE TRAINING

Question: The Administration's justifications previously submitted for the rescission request on the Advanced Nurse Training Program indicate that the impact of the rescission would be the elimination of 50 new projects and 23 continuations. I'm particularly concerned about these continuations. How does this impact on program continuity if you are eliminating these institutional-based projects in mid-stream? Is this fair and equitable?

Answer: For FY 1981, the Advanced Nurse Training Program has 54 grant projects scheduled for continuation. Seventeen of these projects are in the planning phase and have no students enrolled; the remaining 37 projects have a total of 870 students. We would estimate that at least 195 faculty positions are supported by these projects. In the past, schools have terminated faculty who are supported on "soft" monies when those funds are no longer available and the university does not have the resources to maintain them.

NURSING SCHOOL CAPITATION

Question: What percentage of the average nursing school's operating budget can be attributed to the capitation grant program? How will schools make up for the shortfall?

Answer: No current information is available on data regarding schools' operating budgets.

Decreasing capitation funds, combined with decreasing State, local and private financial support, have necessitated increases in student tuition in both public and private schools. Nursing schools will continue to draw on existing sources of income and financial support mechanisms. These include tuition and fees, endorsement funds, non-Federal Government funds, alumni gifts, etc.

Question: What types of nursing schools would be most severely impacted if these rescissions or deferrals were approved?

Answer: Baccalaureate programs, particularly those in private institutions, and newly established programs that do not yet have a firm financial base, would be most severely impacted.

Question: How many schools would be affected overall, and how many students would be involved if the nursing school capitation rescission or deferral were approved?

Answer: More than 1,100 schools of nursing would be affected with a projected enrollment (in 1981-1982 school year) of 202,732 full-time students. (Diploma - 22,011; Associate Degree - 80,031; Baccalaureate - 100,690.)

NURSING PROGRAMS

Question: What is the evidence which led you to eliminate most of the Nursing Programs in 1981 and 1982?

Answer: Evidence cited in the Second Report to Congress (March 1979) concludes that the aggregate supply of nurses would be roughly equal to the aggregate requirements by 1985.

Question: If we already have enough nurses, why do so many hospitals say they are short of nurses and why do we see recruitment bonuses for new nurses?

Answer: There is no simple answer to the problem of nurse shortages in hospital settings. There are a number of factors beyond the purview of the federal government which contribute to this nurse shortage such as : low salaries, lack of autonomy, "burnout", lack of opportunity for upward mobility, work pressures resulting from insufficient staff, etc.

DENTAL TEAM PRACTICE

Question: Why can't the dental schools assume financial responsibility for this program?

Answer: This program does have a requirement for progressive matching funds by the dental schools.

Question: Why is this program needed at all?

The Administration is not requesting funding for this program in fiscal 1982.

Question: What benefit does it provide the dentist and the patient?

Answer: Past Federal funding of this program has resulted in Dentists (or dental students soon to become dentists) being taught how to conduct more efficient dental practices through the utilization of dental extenders, hygienists, and other auxiliaries.

GENERAL DENTISTRY RESIDENCIES TRAINING

Question: The 1982 budget indicates that no funds are being requested for this program in order to direct funds to "other high priority areas." Why is this program deemed to have a lower priority?

Answer: In a time of serious economic problems, the President has indicated that the Federal budget must be constrained. Thus, the Health Resources Administration is emphasizing programs to address high-priority goals such as maintaining a sufficient supply of primary care practitioners and increasing the proportion of minorities and disadvantaged individuals in the health professions that have a high priority than general dentistry.

PUBLIC HEALTH SCHOOLS

Question: With all of the higher education student assistance programs on the books, why is it necessary to continue providing Federal support for training public health professionals?

Answer: Most of the graduates of these training programs enter public employment at the Federal, State, and local levels and another 25% become employed in voluntary health agencies. Neither of these work settings provide salaries high enough to entice applicants to obligate themselves to significant debt for the training required.

Question: Since the Federal government does not seek to remedy shortages in other professional fields such as engineering or computer sciences, what is the rationale for a Federal responsibility in the field of public health?

Answer: The Federal government has an historical commitment assuring high quality preparation of public health professionals to protect the health of the American people. Public and community health policy and programmatic functions are set by publicly determined objectives and health initiatives, many of which emanate from the Federal level. These include numerous legislative actions regarding: (1) disease prevention and health promotion activities; (2) data gathering on the health of population groups and the analysis of this material; and (3) protecting the population against environmental health hazards.

PUBLIC HEALTH SPECIAL PROJECTS

Question: According to your budget justification you are planning interaction between schools of public health and employees of the Center for Disease Control (CDC) and the Health Resources Administration (HRA). Please explain how this will work.

Answer: 1982 Carter budget proposal included this initiative. It included the interaction between the schools of public health, CDC and HRA so that the performance of the State and local health departments can be improved at relatively modest cost by improving management techniques and the application of analytical skills.

The 1982 Reagan budget request provides that limited federal funds will be applied to specific problems in public health through project grants. The CDC/HRA initiative is not included in this proposal.

Question: Will the federal employees have to go to the schools to interact--or will the students and faculty come to them?

Answer: The 1982 Reagan budget proposal eliminates specified funding of the CDC/HRA initiative.

Question: If CDC and HRA are to provide special instructional materials to the public health schools, to what extent will the federal government be reimbursed for this?

Answer: As was previously stated, this effort is no longer planned.

HEALTH TRAINEESHIPS

Question: The programs for public health traineeships and health administration traineeships are separate yet both provide assistance for, among other matters, training in health administration, health policy analyses and health planning. Why do we need two separate programs?

Answer: The current legislative authority, under Section 749 of the Public Health Service Act specifies traineeship grants be awarded to public or nonprofit educational institutions, including graduate schools of social work and excluding schools of public health to support traineeships for graduate study in accredited programs in health administration, hospital administration, or health policy analysis and planning.

Section 748 of the PHS act specifies that traineeships may be awarded to train students enrolled in schools of public health and other public or nonprofit institutions which provide graduate or specialized training in public health and which are not eligible to receive a grant under Section 749.

Question: Why couldn't they be consolidated?

Answer: Consolidation is possible, but would require a change in the authorizing legislation.

ALLIED HEALTH PROGRAM

Question: The 1982 budget indicates that no funds are being requested for the allied health program on the grounds that local community colleges and State universities are responding to the increased demand for allied health professionals by creating new programs and classes. What is the total enrollment in such program and how much has enrollment increased over the last two years?

Answer: The total enrollment in 1979-80 is about 200,000 students, up 25% over the last two years.

IMPACT OF REDUCTION OF HEALTH PROFESSIONS EDUCATION

Question: What impact will these reductions have on the availability of health care professionals in areas where they are needed?

Answer: The Administration is proposing to continue programs which directly impact on the problem of geographic maldistribution of health professionals. The Area Health Education Center (AHEC) program serves as regional educational systems where health professions students receive a portion of their clinical training in facilities located in shortage areas. These programs help address long-term needs by encouraging health professionals to enter practice in shortage areas, thereby insuring people in remote or underserved areas better access to health services.

Program support will continue for primary care programs to train physicians in order to make available adequate primary care services in urban and rural areas. The 1982 budget also provides support for the Nurse Practitioner program. These practitioners will deliver much needed medical services in urban and rural underserved areas to all age groups especially those who have limited access to health care such as mothers, infants, children, the chronically ill and the aged.

GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS

Question: When can Federal financial assistance be phased out for this program?

Answer: New health professions legislation to be proposed would continue the authority for programs in general internal medicine and pediatrics, combining it with the family medicine residencies and training program.

START-UP ASSISTANCE

Question: If the $1.7 million currently available for Start-up assistance is not rescinded, as the budget requests, what will you do with this money?

Answer: Two schools of osteopathy would have received funds for their third and final year under this program:

College of Pacific, CA............	$405,000
New England College, N.H..........	$400,000

Two schools of veterinary medicine would have received funds for the third year of a planned four year funding cycle:

Tufts University, MA..............	$385,000
Virginia Polytechnic Institute and State University..........	$600,000

PHYSICIAN ASSISTANTS

Question: Don't physician assistants help solve the problem of geographical maldistribution of medical care?

Answer: Data indicate that the majority of physician assistants are providing primary care services in areas of need. A recent Congressional Budget Office Report indicates that they may be making more care available to people with limited access to health care because of the rural-urban distribution of physician assistants. The data also indicate that physician assistants practice in non-metropolitan areas more frequently than physicians.

EMERGENCY MEDICAL TRAINING

Question: The budget narrative indicates that you are terminating the Emergency Medical Training program on the grounds that it is a local responsibility. At the same time, the Health Services Administration is continuing the Emergency Medical Services Grant Program. If grants for Emergency Medical Services are a Federal responsibility, why isn't is also a Federal responsibility to provide for the training of the personnel needed to carry out the services?

Answer: The Emergency Medical Services (EMS) legislation provides incentives to communities to overcome barriers to regionalization of emergency medical services. The intent is that the public and private sectors should support the EMS systems financially once the systems were in place. EMS systems grant application requirements are written so that EMS systems must develop community-based sources of funding for continued operation of the system after they are no longer eligible for Federal support. Hopefully, community resources will continue EMS services after Federal funding stops. Since training is a required component of each EMS system, future financial resources for this component will also be obtained from local community resources.

FAMILY MEDICINE RESIDENCIES AND TRAINING

Question: Why does the budget estimate for this program envision a reduction of approximately 1,600 positions to be supported in Fiscal Year 1982?

Answer: The position numbers you refer to were associated with the previous budget submitted by the Carter Administration. This Administration's budget will provide for a modest increase in this program area.

Question: Why does the average cost intern/resident in the graduate program increase by 21% in 1982 compared to 1981?

Answer: The average cost comparison you refer to is also taken from the Carter Administration budget proposals. We do expect costs per resident to increase somewhat in F.Y. 1982 due to inflationary pressures.

IMPACT OF REDUCTION IN HEALTH PROFESSIONS EDUCATION

Question: President Reagan is proposing to cut the budget for Health Professions Education to $120 million in 1982 compared to a level of $169 million in the Carter budget and $343 million in 1980. Where will these reductions be taken?

Answer: The program reductions for health professions is shown on the following table:

Impact of FY 1982 Reagan Budget Proposal

				Change in 1982 Reagan Budget	
BHPr Programs	(1) 1980 Rev. Continuing Resolution	(2) 1982 "Carter" Budget	(3) 1982 "Reagan" Budget Reqt	(4) From 1980 Cont. Resol.	(5) From 1982 Carter Budget
HEALTH PROFESSIONS					
Institutional Assistance					
Capitation..............	$73,568	—	—	-$73,568	--
MOD...................	(57,721)	--	—	(-57,721)	--
VOPP..................	(9,397)	—	—	(-9,397)	—
PH.....................	(6,450)	—	—	(-6,450)	—
Financial Distress......	7,400	$9,400	$7,400	--	-$2,000
Start-up................	2,700	--	—	-2,700	—
Subtotal, H.P.I.A.....	$83,668	$9,400	$7,400	-$76,268	-$2,000
Dental Health Education					
Gen. Dent. Resid. & Trng.	$4,050	—	--	-$4,050	—
Team Practice Grants....	2,000	$1,180	—	-2,000	-$1,180
Den. Extenders (EFDA)...	2,000	--	—	-2,000	—
Subtotal, Dental......	$8,050	$1,180	--	-$8,050	-$1,180
Public Health/Hlth Admin.					
Special Projects - P.H.	$5,000	$7,400	$5,500	-$2,500	-$4,900
Health Admin. Grants....	3,000	3,000			
Public Health Trnshps...	7,000	5,200	500	-8,500	-6,100
Health Admin. Trnshps...	2,000	1,400			
Subtotal, P.H /H A ...	$17,000	$17,000	$6,000	-$11,00	-$11,000
Primary Care					
Fam. Med. Res. & Trng...	$36,450	$29,150	Primary Care	-$9,950	-$2,650
Gen. Inter. Med. & Ped..	19,500	12,792	8,000	-11,500	-4,792
Family Medicine Depts...	9,500	9,500	$36,000	—	--
Subtotal Prim. Care.....	$65,450	$51,442	$44,000	-$21,450	$7,442
Special H.P. Initiatives					
Physician Assistants....	$9,100	$7,300	$5,000	-$4,100	-$2,300
G.M.E...................	500	500	500	—	--
Emergency Med. Trng.....	3,000	--	--	-3,000	--
A.H. Spec. Proj./MEDIHC	5,808	—	--	-5,808	--
Allied Hlth Traineeshps	892	--	--	-892	—
Subtotal, Spec. H.P.I.	$19,300	$7,800	$5,500	-$13,800	-$2,300
Preventive Medicine Residencies and Depts..	—	--	$3,000	+$3,000	+$3,000
Special H.P. Initiatives	--	—	5,000	+5,000	+5,000
HP Ed Impr. & Dev. Proj	$8,500	—	—	-8,500	—
Area Hlth Educ. Ctrs....	21,000	$15,300	15,800	-5,200	+ 200
HP Anal. Stdy & Repts...	2,700	2,583	2,585	-155	—
Disadvantaged Assist....	19,568	30,000	19,568	—	-10,432
Subtotal Hlth Prof Ed..	$243,236	$134,705	$108,853	-$136,383	-$25,852
NURSING TRAINING					
Capitation..............	$24,000	—	—	-$24,000	—
Special Projects........	15,000	$5,438	$6,432	-8,568	+$944
Advanced Nurse Training	12,000	—	1,300	-10,700	+1,300
Nurse Practitioner......	13,000	17,000	6,500	-6,500	-10,500
Prof. Nurse Trneeshps...	13,000	—	--	-13,000	—
Fellowships.............	1,000	--	—	-1,000	--
Research Grants.........	5,000	—	--	-5,000	—
Subtotal, Nurse Trng...	$83,000	$22,438	$14,232	-$68,768	-$8,206
Subtotal, Hlth Prof Ed	$328,236	$157,143	$123,085	-$205,151	-$34,058
Program Support (BHPr)..	14,823	12,441	3,000	-11,823	-9,441
TOTAL BHPr.............	$343,059	$169,584	$126,085	-$216,974	-$43,499
Positions...............	413	309	100	-313	-209

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

Question: Why is it necessary to request an appropriation of $35 million for this account when unobligated balances plus anticipated loan repayments are more than enough to meet the cost of required interest subsidy payments?

Answer: Loan repayments, whether on Federally guaranteed loans or on direct loans, are not available for the payment of interest subsidy. Repayments on guaranteed loans are made to the lender and not to the Federal government. The only significant repayments on direct loans are those made on direct loans which have been sold through the Federal Financing Bank. Thus, these repayments are simply passed through to FFB. Moreover, interest subsidy is paid only from appropriations made for that purpose. No request was necessary to meet the interest subsidy payments in 1981 because adequate funds were available from previous years' appropriations. Payments in 1981 will eliminate all but a small portion of the balance; therefore, $35 million is required.

Question: How long will it be necessary to make interest subsidy payments under this program?

Answer: The standard period for loan amortization is 25 years, and since the last loan closing is scheduled for 1981, the mandatory interest subsidy will have to be paid until the year 2006.

DUPLICATION AND IMPLEMENTATION

Question: In many areas of the country, local health departments develop health programs and services for their community. To do this they must have information on the health needs of their community, and the services already available. Since HSAs have no authority or resources to implement their plans and are essentially outside the political structure of a community, what can we realistically expect in the way of implementation?

Answer: Eventhough HSAs have no authority or resources to implement their plans, many agencies have been successful in implementation efforts by working closely with providers and public elected officials.

Question: If we can't expect much in the way of implementation, haven't we cast a great deal of doubt on the value of developing the plans?

Answer: The value of the plans rest with their actual use in the review of proposed changes to the health care delivery system and the degree to which the plan is used as a tool for implementation, and the degree to which these plans have resulted in accomplishing our overall objectives.

Question: Obviously, the health planning system has multiple goals which are not always compatible. Maybe this will prove to be their undoing. Suppose the planning system is eliminated, as President Reagan wants, what would be the effect in a typical planning area? Have the HSAs imposed an order that would not be there without them or that will disintegrate if they disappear? Would costs be likely to rise?

Answer: In some areas the focus of the planning program has been on improving access to care while in others the major thrust has been in reducing costs by such activities as decreasing duplication. Just as the focus varies greatly from area to area, the actual impact of the reduction will vary. Some communities may realize substantial increase in costs in the absence of the capital review activities by the HSAs; and others are expected to continue the type of activities begun under the planning program with non-Federal sources of funding.

PHYSICIAN ASSISTANTS

Question: In light of the favorable reports on the work of physician assistants by the Congressional Budget Office and others, why does the Carter Budget propose a $1.8 million cut in this program?

Answer: In view of overall fiscal constraints and the limited resources available for health professions training, the Reagan budget proposes to target funding to those programs which have the most potential for solving current high-priority health professions training programs. As part of this strategy, the Reagan budget includes $5.0 million for physician assistants in 1982.

HEALTH PROFESSIONS PROGRAM SUPPORT

Question: Total obligations for health professions grants are projected to decline from $81.8 million in 1980 to $22.4 million in 1982, a decrease of 73%. However, the number of positions in program support declines for 413 in 1980 to 309 in 1982, a decrease of only 25%. Why isn't the decline in the number of support personnel commensurate with the decline in program dollars?

Answer: Total program dollars in the Bureau of Health Professions declines from $328.2 million in 1980 to $123.1 million in the 1982 Reagan budget with positions decreasing from 413 to 100. These reductions represent a 63% reduction in dollars and a 52% reduction in positions. We feel that this personnel reduction is commensurate with the program reductions.

PROGRAM MANAGEMENT

Question: The three elements of HRA each have a sizable program management staff--272 in Health Planning, 155 in Health Facilities, and 309 in Health Professions, for a total of 736. At the same time, the Office of the Administrator has 208 people to manage the work of three sub-agencies. Why do you need 208 people to oversee the work being done by 736?

Answer: As a result of the recent budget revisions, the 1982 position request for the Bureau of Health Planning has been reduced to 10, Health Facilities to 149, Health Professions to 100 and Program Management to 50. The staff of the bureaus and program offices within the Health Resources Administration are allocated to those specific tasks which relate most directly to the day-to-day conduct of the operations which carry out each of the respective programs. These programs are diverse, and require a mix of technical skills and background, most of which are specific to a particular program or group of programs. The 50 positions for program management in the Office of the Administrator serve a different purpose than the positions allocated to the bureaus. These 50 positions are for a number of discrete functions appropriate to the agency level, and range from agency-wide direction and resolution of cross-cutting program issues to a variety of centralized common services which support all program operations, such as mail deliveries, printing, and personnel management. These functions are inherent in an operating agency, and must be performed. Given the relatively small size of the Health Resources Administration and the fact that the entire agency (with the exception of staff in the 10 regional offices) is located at a single site (The Center Building in Hyattsville, Maryland), most of these functions are centralized at the agency level for economy of scale.

The level of 50 program management positions is consistent with the program activity levels specified in the original FY 1982 budget submission to the Congress.

PRO's and CON's OF HEALTH PLANNING

Question: How many HSAs are adequately staffed to perform the multiple responsibilities assigned to them?

Answer: The law requires agencies to employ one professional staff member for each 100,000 population, with a minimum of five and a maximum of 25 professional staff members. The law also requires staff expertise in at least six areas specified.

Most agencies have staffs which meet these requirements. Minimally funded and rural agencies have the greatest difficulty attracting qualified personnel, and agencies with 5-member staffs frequently have difficulty meeting expertise requirements.

Question: Can you document how many agency staff have been affected by cutbacks in levels of HSA funding?

Answer: The decrease in funding from $124.7 million in FY 80 to $101.7 million in the FY 81 Continuing Resolution has resulted in a variety of cutbacks by the agencies. The major area affected has been staff reductions. The following examples represent the degree of impact on staffing:

- o The Central Maryland HSA has eliminated 12 positions (1/4) from their staff.
- o The Health Resources Planning and Development, Inc., in Pennsylvania, has given notice to 6 of their 11 professionals that their services will be terminated on March 15.

THREAT TO COMPETITION

Question: Would competition occur in the absence of the health planning program, and if so, what sort of competition--cost-effective or cost-inflating?

Answer: In general, the Administration does not believe that Federally funded health planning has been successful in restraining health care costs. These costs have risen at a rate far in excess of the Consumer Price Index. The Administration thinks that Federally funded health planning has inhibited cost effective competition by restraining free entry into the health care market. Eliminating these barriers is expected to promote the effective functioning of private market forces in the health care sector.

Question: Would some form of health planning take place at the local and State level in the absence of Federal support?

Answer: Some form of health planning will take place in some states and local areas.

There are now eighteen local agencies which are parts of public regional planning bodies, five are units of local government and the remainder are private nonprofit organizations. It is possible that some of these and other local agencies will be sustained in part by local contributions.

In addition, approximately thirty local business coalitions for health planning are in place. Nearly all have at some point interacted with health planners and some are physically housed in HSA offices. It is possible that many of these will continue to exist.

PLANNING - COST CONTAINMENT PROGRAM

The budget now before Congress proposes a cost-cutting plan to reduce hospital beds and improve coordination with State Rate Review programs.

Question: To what extent would it be possible for you to initiate such a program with only a portion or without the additional $13 million you seek for State planning agencies?

Answer: The plan to which you refer will not be implemented by the current Administration. The Reagan budget for health planning proposes a phase out of Federal funding by fiscal 1983. The additional $13 million would be used to effect an orderly phase out.

Question: To what degree have you considered initiating this as a limited demonstration program?

Answer: As mentioned above, this initiative will not be implemented by the current Administration.

PLANNING METHODS DEVELOPMENT

You presently have four Centers for Health Planning too, which among other matters, provide technical assistance to health planning agencies.

Question: Why should the Federal Government continue to support these Centers? Can't the Health Systems Agencies develop their own means of technical assistance if they deem it necessary?

Answer: In providing for a Centers program, Congress recognized a need to create a number of Centers with multidisciplinary health planning and development expertise for the conduct of research, studies, and analyses of health planning; to develop health planning approaches, methodologies, policies, and standards; and provide such assistance and dissemination of information as the state and local health planning agencies require. The Centers provide expertise on a continuing basis which means that the health planning agencies do not have to rely on consultants on an ad hoc basis, or spend a great deal of time and expense educating them about the complexities of the planning program.

We initially funded ten Centers in 1976, one in each of the Department's ten regions. There was a need at that time for a great deal of technical assistance to the State and local agencies to assist them in organizing, establishing their governing bodies, and in initiating plan development and project review activities. As the health planning program matured, and the agencies shifted away from organizational issues, the focus of the Centers program shifted as well.

In 1979, we reduced the number of Centers from ten to four and directed them to focus their technical assistance on specific subject areas. Due to funding restrictions and the larger geographic areas covered by each of the Centers, we directed that they provide technical assistance to individual agencies only if the individual agency requested specific assistance and was willing to pay for it. This has been beneficial in two ways: (1) individual agencies needing specific assistance did call on the Centers for assistance; and (2) the Centers provided more assistance on a multi-agency and multi-state basis. This has increased the cost effectiveness of the technical assistance, and also provided a vehicle for agencies to share both their problems and solutions with one another.

Continued support of the Centers is now necessary in 1982 to assist the planning agencies in an orderly phaseout of Federal funding.

Question: How do you know whether these Centers are effective? What measures do you use?

These cutbacks in staff will obviously mean limited implementation and will curtail project review. The additional funding reductions in FY 81 and those proposed in 1982 will cause many more agencies to cut back staff as they move towards phase out of Federal support.

DISADVANTAGED ASSISTANCE

Question: Why is it necessary to expand the funding for this program by over 50% for FY 1982?

Answer: As a result of the 1982 budget revisions recently submitted to Congress, the request for the disadvantaged assistance program in 1982 would provide the same dollar level ($19,568,000) as is available in 1981 under the Continuing Resolution.

SUBCOMMITTEE RECESS

Senator BURDICK. I want to thank you and all the witnesses for your contribution and cooperation this morning.

The subcommittee will stand in recess until 2 p.m., Monday, February 23, when we will meet again in this room to hear fiscal 1982 budget requests from the Office of Assistant Secretary for Health.

[Whereupon, at 11:10 a.m., Friday, February 20, the subcommittee was recessed, to reconvene at 2 p.m. on Monday, February 23.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

MONDAY, FEBRUARY 23, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2 p.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. James Abdnor presiding.

Present: Senators Abdnor and Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF ASSISTANT SECRETARY FOR HEALTH

STATEMENT OF CHARLES MILLER, ACTING ASSISTANT SECRETARY FOR HEALTH OPERATIONS

ACCOMPANIED BY:

- RUTH S. HANFT, DEPUTY ASSISTANT SECRETARY FOR HEALTH RESEARCH, STATISTICS AND TECHNOLOGY
- DR. J. MICHAEL McGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DISEASE PREVENTION, AND PROMOTION
- HOWARD VEIT, DIRECTOR, OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS
- DR. VINCE L. HUTCHINS, M.D., ACTING DIRECTOR, OFFICE OF ADOLESCENT PREGNANCY PROGRAMS
- PETER J. BERSANO, DIRECTOR, OFFICE OF RESOURCE MANAGEMENT, PUBLIC HEALTH SERVICE
- ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET
- DR. JOHN H. BRYANT, M.D., DIRECTOR, OFFICE OF INTERNATIONAL HEALTH
- JOHN PINNEY, DIRECTOR, OFFICE ON SMOKING AND HEALTH
- JACK N. MARKOWITZ, ACTING DEPUTY ASSISTANT SECRETARY FOR HEALTH OPERATIONS

SUBCOMMITTEE PROCEDURE

Senator ABDNOR. The subcommittee will come to order.

Appearing before us today is Mr. Charles Miller, Acting Assistant Secretary for Health. During this afternoon's session we will be discussing programs administered by Mr. Miller's office, as well as an overview of other public health service programs.

Mr. Miller, at this time I would like to extend the subcommittee's welcome. We have numerous questions to address to you, but before we begin would you please introduce your associates and then proceed with a brief overview of the program under your jurisdiction.

INTRODUCTION OF ASSOCIATES

Mr. MILLER. Thank you, Mr. Chairman.

Sitting on my far left is Mr. Howard Veit, the Director of the Office of Health Maintenance Organizations. Next to him is Dr. Michael McGinnis, Deputy Assistant Secretary for Health Disease Prevention and Health Promotion. Sitting on my left is Mr. Peter Bersano, Director, Office of Resource Management, Public Health Service.

On my immediate right is Mrs. Ruth Hanft, Deputy Assistant Secretary for Health Research, Statistics, and Technology. And sitting on her right is Mr. Tony Itteilag, Acting Deputy Assistant Secretary, Budget.

Also in the room, and I may be calling on them to help me with questions, Mr. Chairman, are Dr. Jack Bryant, who is the head of our Office of International Health; Dr. Vince Hutchins, the Acting Director, Office of Adolescent Pregnancy Programs; and also Mr. John Pinney, sitting behind me, who is the head of our Office on Smoking and Health. Also Mr. Jack Markowitz, Acting Deputy Assistant Secretary for Health Operations.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH (OASH) MISSION

Mr. Chairman, I will start now with the overview, if I may. The Office of the Assistant Secretary for Health really has two missions, and sometimes they get confused.

[The information follows:]

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH—PUBLIC HEALTH SERVICE

MANAGEMENT AND COORDINATION

Sets priorities for health agencies; allocates resources; program coordination—crosscutting issues; and administrative management.

PUBLIC HEALTH SERVICE AGENCIES

Mr. MILLER. The first, and most important mission, is to be the office which is responsible for managing the six Public Health Service agencies, for allocating resources among them, for developing Public Health Service policy, coordinating what I call crosscutting issues, and I will discuss those in a little greater length in a minute, and then also providing administrative management services.

When I mention that it is responsible for managing the Public Health Service agencies, Mr. Chairman, I think I do need to mention that the Public Health Service is made up of the National Institutes of Health, the Centers for Disease Control, Health Services Administration, the Health Resources Administration, the Alcohol, Drug Abuse, and Mental Health Administration, all of whose appropriations you have heard previous to mine.

Also, the Food and Drug Administration is part of the Public Health Service, but its appropriation is heard by the Agriculture Subcommittee.

While the primary mission of the Office of the Assistant Secretary for Health does involve the development of policy and the allocation of resources, public health servicewide, by far the preponderance of the appropriation is devoted to a set of operating programs that I will describe to you when we turn to the next chart. But in fact, 85 percent of the resources that we request for the Office of the Assistant Secretary for Health are for direct operating programs similar to those administered by the six Public Health Service agencies.

I did mention that I wanted to describe a bit what I meant by the term crosscutting issues. One of the most important functions of the Office of the Assistant Secretary of Health, particularly as the field of health becomes increasingly complex, is to provide coordination of the programs which cut across the six agencies. The best three examples that I think you would be aware of would be the programs that deal with the environment, programs which deal with health prevention and health promotion, programs which deal with child health.

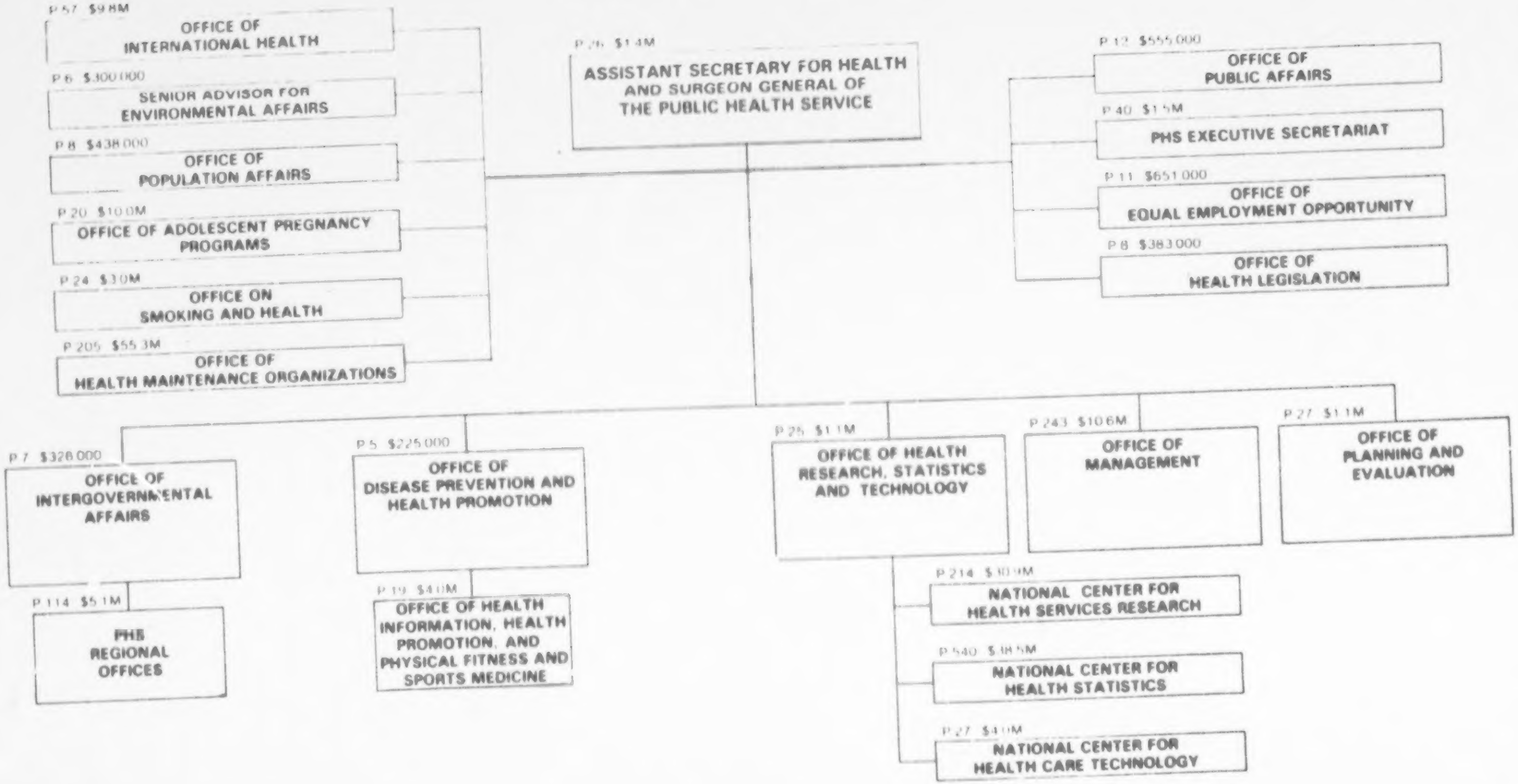
ORGANIZATION CHART

Now, if I may, I would like to turn to a fairly complicated organizational chart and move rather quickly through it.

[The chart follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE


P 26 $1.4M
ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE
P 57 $9.8M
OFFICE OF INTERNATIONAL HEALTH
P 6 $300,000
SENIOR ADVISOR FOR ENVIRONMENTAL AFFAIRS
P 8 $438,000
OFFICE OF POPULATION AFFAIRS
P 20 $10.0M
OFFICE OF ADOLESCENT PREGNANCY PROGRAMS
P 24 $3.0M
OFFICE ON SMOKING AND HEALTH
P 205 $55.3M
OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS
P 12 $555,000
OFFICE OF PUBLIC AFFAIRS
P 40 $1.5M
PHS EXECUTIVE SECRETARIAT
P 11 $651,000
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY
P 8 $383,000
OFFICE OF HEALTH LEGISLATION
P 7 $328,000
OFFICE OF INTERGOVERNMENTAL AFFAIRS
P 114 $5.1M
PHS REGIONAL OFFICES
P 5 $225,000
OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION
P 19 $4.0M
OFFICE OF HEALTH INFORMATION, HEALTH PROMOTION, AND PHYSICAL FITNESS AND SPORTS MEDICINE
P 25 $1.1M
OFFICE OF HEALTH RESEARCH, STATISTICS AND TECHNOLOGY
P 214 $30.9M
NATIONAL CENTER FOR HEALTH SERVICES RESEARCH
P 540 $38.5M
NATIONAL CENTER FOR HEALTH STATISTICS
P 27 $4.0M
NATIONAL CENTER FOR HEALTH CARE TECHNOLOGY
P 243 $10.6M
OFFICE OF MANAGEMENT
P 27 $1.1M
OFFICE OF PLANNING AND EVALUATION

OPERATING PROGRAMS

Mr. MILLER. The final chart will provide you a set of tables which will show you the dollars that are requested for each of these components. First, I would like to turn to the operating programs of the Office of the Assistant Secretary of Health; and if I may, I would explain to you that there are primarily two reasons why there are operating programs in what is normally thought of as a coordinating office.

First and foremost, probably, and it applies to the first of the operating group that I want to talk about, is the fact that some of these programs are programs which deal with all of the six agencies and need the clout, if you will, of the Office of the Assistant Secretary for Health to get the attention of each of the agencies involved. The first of these is the Office of Health Research, Statistics, and Technology, which includes three centers: The National Center for Health Services Research, which does research on such matters as the organization and delivery of health service, and except for the behavioral research in the Alcohol, Drug Abuse, and Mental Health Administration, is, I guess, the only place in the Public Health Service where nonbiomedical basic scientific research is performed.

The second of the three centers is the National Center for Health Statistics, which grows out of the old Office of Vital Statistics, and provides the data base for all of the health programs for the entire Nation.

Finally is the National Center for Health Care Technology, which was established as recently as 1978, to take a look at the new procedures and new matters that are coming into the health field, to determine their cost and determine their efficacy, and sometimes to provide advice to both medicare and medicaid as to what their reimbursement policies should be with respect to those matters.

The second large operating program in the Office of the Assistant Secretary for Health is the Office of Health Maintenance Organizations, and I think probably you know what that program is. It's a program that's been in existence for about 8 years now, which provides what we regard as a very cost-effective method of health financing, and which emphasizes the health prevention aspects of health programs.

Another operating program in the Office of the Assistant Secretary for Health is the Office of Adolescent Pregnancy Programs, which too has only been established as recently as 1978. And it was established in response to a very definite problem which has been growing throughout the Nation for the past decade or so, of unwanted pregnancy among teenage women. And that program provides the opportunity to bring together a comprehensive approach to the whole matter of unwanted pregnancy, and to help the youngster either prevent pregnancy or to help to take care of her child if she brings the pregnancy to term.

POLICY DEVELOPMENT AND COORDINATION

The rest of the offices in the Office of the Assistant Secretary for Health are offices which primarily are responsible for the policy development and coordination to which I referred. The Office of Management performs the normal functions that I think you all are aware of, having to do with budget and other matters of finances and with grants and contracts management, and with personnel management.

The Office of Planning and Evaluation helps to develop legislation to evaluate whether programs are in fact having the impact that we hope they will.

These are several examples. I don't think you want me to go through every office. I do want to mention the Office of International Health, which Dr. Bryant heads. With a small staff and few resources, they perform a very important function working with the World Health Organization doing work for AID in developing bilateral agreements with nations and in assisting the Secretary of Health and Human Services and the Secretary of State on very important matters of international health policy.

Next the Office on Smoking and Health, which coordinates the work that goes on throughout the Public Health Service, in our efforts to determine the epidemiological data about smoking and to advise the Nation on what direction we should take in this very important prevention program.

Finally, there is the Office of Disease Prevention and Health Promotion, which coordinates prevention activities and health education activities throughout the Public Health Service.

One final word before turning to the chart. I mentioned that one of the reasons we have operating programs in the Office of the Assistant Secretary for Health is because of these coordinating activities. There are some activities which are in the Office of the Assistant Secretary for Health by statute. They include the Office of Adolescent Pregnancy, the Office of Health Information and Health Promotion, Physical Fitness and Sports Medicine, and the Deputy Assistant Secretary for Population Affairs.

[The information follows:]

OFFICE OF THE ASSISTANT SECRETARY OF HEALTH

[In thousands of dollars]

	1980	1981
Program operations:		
Health services research	29,906	30,857
Health statistics	43,332	38,512
Health care technology	3,250	3,989
Program management (research, statistics, and technology)	1,016	1,079
Health maintenance organizations	54,390	55,250
Health initiatives:		
Adolescent health services	7,500	9,993
Smoking and health	2,519	2,995
Health promotion	1,664	3,275
Physical fitness and sports	893	929
International health	733	779
Total, program operations	145,203	147,658
(Positions)	(1,094)	(1,102)

OPERATING PROGRAMS

Mr. MILLER. Now, Mr. Chairman, we'll turn to the next chart. In terms of dollars, I want to make a few points which are on the next chart after this one. This chart in front of you now contains the dollars that are associated in fiscal years 1980 and 1981 for each of the activities that I have already described, which we regard as being operating programs.

[The information follows:]

OFFICE OF THE ASSISTANT SECRETARY OF HEALTH

[In thousands of dollars]

	1980	1981
Total, program operations	145,203	147,658
(Positions)	(1,094)	(1,102)
Public Health Service management:		
Regional management	5,351	5,374
Program direction and support services	16,937	16,904
Total	21,748	22,278
(Positions)	(509)	(502)
Total, Office of the Assistant Secretary	166,951	169,936
(Positions)	(1,603)	(1,604)
Retirement pay and medical benefits for commissioned officers	75,808	91,958

OVERHEAD

Mr. MILLER. Turning to the next chart, there is a summary of the categories into which the appropriation is broken. The first is the program operations that I just mentioned. As you'll notice under the fiscal year 1981 continuing resolution, there is $147 million associated with those program operations, and roughly 1,100 people.

Then turning to the coordinating or what is sometimes termed the overhead functions of the Office of the Assistant Secretary for Health, there is a total of about $22 million and approximately 500 people. So that a total for that part of the appropriation that is before you is roughly $170 million.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

There is one other separate appropriation that is before you that is entitled "Retired Pay and Medical Benefits for the Commissioned Officers" in the Public Health Service. That is the only entitlement program in the entire Public Health Service, and it provides the appropriation for the pay of retired commissioned officers and for the medical benefits of the dependents of those who are currently on duty.

And that, Mr. Chairman, winds up my overview statement. If you will, I would like to file my longer opening statement for the record, and would be glad to take questions.

Senator ABDNOR. No objection. It will be placed in the record.

[The statement follows:]

STATEMENT OF CHARLES MILLER

I am pleased to be here today to talk about the activities within this office.

ASSISTANT SECRETARY FOR HEALTH

The Office of the Assistant Secretary for Health is responsible for planning and directing the mission of the Public Health Service as well as administering a number of health initiatives which represent high priority efforts.

National Center for Health Services Research

The National Center for Health Services Research (NCHSR) conducts and supports research, demonstrations, and evaluations on problems in the organization, delivery, and financing of health services. The program is designed to provide needed information to government, the health industry, and consumers of health services.

The Center supports research that will affect health legislation, policy, the health care industry, and could result in significant savings and improvements in health care for the American public. Examples include recent studies that suggest that alternatives to institutional care for the elderly, such as home care and day care centers, do not achieve the expected savings or beneficial health effects; that generic drug substitutions were made in only 2.8 percent of the possible 15 million prescriptions; and that heart attack victims who experience no complications during the first four days of illness can be considered for discharge on the seventh day of hospitalization - eight to ten days sooner than the average.

National Center for Health Statistics

The National Center for Health Statistics is the principal Federal program for the collection, maintenance, and dissemination of general purpose health statistics and vital events for the Nation such as births, deaths, marriages and divorces. Statistics are produced on a wide range of topics including the health and nutritional status of the population, the extent and nature of illness and disability of the population, and the costs of health care. The information and statistics gathered are essential for the effective planning and program development of the health, academic, and research communities, public and private groups, private citizens and Federal agencies. Data developed by the Center are annually published in Health, United States which is widely disseminated to the public and health agencies.

National Center for Health Care Technology

The National Center for Health Care Technology is the focal point in the Department for technology assessment and resolution of technology-related issues. In large part, these activities are aimed at stimulating the rapid diffusion of cost-effective technologies into the medical care system and, in turn, improving the health status of the Nation's people by supporting analyses of the safety, efficacy, and cost-effectiveness of new and existing health care technologies, and by reviewing the ethical, social, and economic impacts of specific health technologies. Technologies to be focused on are identified by the National Council on Health Care Technology, the Health Care Financing Administration, and the Department's Technology Coordinating Committee. The Center has recently published or held consensus conferences on maternal serum alpha-fetoprotein - a technique for detecting neural tube defects, dental x-rays, cervical cancer screening, and Caesarean delivery. In 1981, a conference on coronary bypass will be held.

Health Maintenance Organizations

The Health Maintenance Organization program seeks to increase the availability of high quality health care at a reasonable cost. Evidence indicates that HMOs provide significant benefits to consumers, employers, and government. For example, the total cost of health care for HMO members is 10-40 percent less than for people with comparable health insurance.

This program supports management training and technical assistance activities to alleviate the shortage of skilled HMO managers by attracting new managers to the industry and upgrading the skills of current managers. Technical assistance is provided to grantees and qualified HMOs by teams of experts who are made available to organizations experiencing major problems in operational areas such as marketing and finance.

The HMO Loan and Loan Guarantee Fund serves as a mechanism to provide working capital during the initial operating period of an HMO when operating deficits are expected and to assist HMOs in the establishment of ambulatory health care facilities.

Health Initiatives

Included under this category are five programs which have as their goal the improvement of health by promoting beneficial changes in lifestyles and individual health practices.

The Adolescent Health Services program provides coordination, integration, and linkage grants to help communities bring together Federal, state, and private funding to support efforts directed toward reducing the incidence of unwanted adolescent pregnancies and providing comprehensive services to the pregnant adolescent, adolescent parents, and their children. It is estimated that for every dollar in this program an additional two dollars of existing Federal, State, or private sector money is spent for these services. Technical assistance is provided to grantees in an effort to develop innovative approaches to meeting the health, educational, and social services needs of the pregnant adolescent and adolescent parents.

Efforts to develop, implement and coordinate a national smoking and health program are part of the disease prevention objectives. These activities are designed to enable current smokers to make an informed decision about their smoking habits and to discourage children and adolescents from initiating the habit. The ultimate goal of these programs is to reduce deaths, disabilities, and health care costs associated with the Nation's number one preventable health problem, cigarette smoking.

The Health Promotion program is designed to prevent disease and disability by enhancing individual perspective on preventive health actions. This is accomplished by encouraging the establishment of programs and special projects in the private sector and through the activities of the National Health Information Clearinghouse. Other efforts include identifying and coordinating the activities of the Department, other Federal, state, local and non-government agencies involved in health promotion activities; the development of and use of measurable prevention objectives; and education of the public about factors affecting health and the use of the health care system.

The Physical Fitness and Sports activity encourages employee fitness programs, state and local exercise programs, and develops fitness programs tailored to individuals at different life stages. This activity also provides staff support and assistance to the President's Council on Physical Fitness and Sports.

The International Health activity provides leadership in the development of U.S. international health policy and intragovernmental planning and coordination in cooperation with the Department of State, Agency for International Development and other concerned agencies.

Public Health Service Management

This activitity has responsibility for the overall management of Public Health Service programs. Activities included are the development of strategies and plans for accomplishing national health goals, policy analysis of PHS agency programs, review and analysis of agency management practices and other centralized management functions. Key examples of the management responsibilities include financial management, manpower utilization, grants and contracts management and regional office management. The financial management staff provides review, analysis and assistance in the development of PHS agency budget submissions, establishes relevant policies and provides technical assistance to and monitoring of agency accounting systems. The manpower utilization effort involves the conduct of management studies, provision of technical assistance and review of consultant services plans, and the provision of technical assistance in ADP management and systems development. The grants and contracts management function establishes and administers PHS grant and contract policies and procedures, controls year-end procurement spending, stimulates greater use of competitive contract awarding, and encourages the awarding of contracts to small and minority enterprises. The regional management staff provides support for the Regional Health Administrator by maintaining uniform management systems to ensure that PHS policy is reflected in regional activities and programs and that these programs are responsive to state and local needs.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

This appropriation provides mandatory retirement payments to retired PHS Commissioned Officers and survivors of deceased officers. Funds are also used for medical care for dependents of eligible personnel of the Coast Guard, the National Oceanic and Atmospheric Administration, and the Public Health Service, and to retired members of these services.

REGULATIONS BUDGET

The Office of the Assistant Secretary for Health (OASH) is responsible for the development and issuance of regulations for the programs funded under this appropriation and has a review and technical assistance responsibility relating to the regulations activities of the PHS agencies. It is estimated that $2.3 million and 75 work years will be required in 1981.

As part of the overall PHS management responsibility, the OASH staff also reviews and coordinates the development, promulgation, and application of regulations required in the administration of PHS agency programs. Specifically, OASH monitors and develops PHS policies and procedures for initiating, drafting and approving new and revised regulations; provides technical assistance to PHS agencies for the development and promulgation of regulations; acts as a focal point for implementing Departmental and Administration directives concerning regulations; reviews all new and revised regulations for compliance with PHS, Departmental and Administration policy and monitors PHS agency grant and contract administration activities to ensure consistent application of established regulations. For the overview function in OASH, it is estimated that 9 work years at a cost of $325 thousand will be required in 1981.

Grant programs for which OASH has responsibility for the development, promulgation, and enforcement of regulations include health services research, health care technology, adolescent health, and health maintenance organizations. Regulations for these programs are presently in effect and no development or promulgation costs are anticipated in 1981 or 1982. A unique responsibility of the health maintenance organizations program is the certification of those health maintenance organizations (HMO's) seeking to avail themselves of federal support. After an HMO is certified as federally qualified, the program monitors qualified HMO's for continued compliance with regulations established for that purpose. It is estimated that $2.0 million and 66 work years will be required in 1981.

Mr. Chairman, I will be pleased to answer any questions you may have on these programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Biographical Sketch

NAME	Charles Miller II
POSITION	Acting Assistant Secretary for Health
BIRTHPLACE AND DATE	Philadelphia, Pennsylvania, November 22, 1923
EDUCATION	BA, Princeton University 1947, Major, History MA, University of Pennsylvania 1948, Major, Political Science
HONORS	Graduated Cum Laude from Princeton, 1947 Elected to National Social Science Honor Society (Pi Gamma Mu) 1948 Superior Service Award, DHEW, 1964 Quality Salary Increase, November 1968 Distinguished Service Award, April 1972

Secretary's Special Citations, January 1973,
August 1975, and December 1976
President's Distinguished Executive Award
(Senior Executive Service) $20,000, 1980

MILITARY SERVICE 1943-1946, U.S. Army, 2nd Lieutenant

EXPERIENCE

1/81 - Pres.	Acting Assistant Secretary for Health
4/78-1/81	Deputy Assistant Secretary for Health Operations
3/77-4/78	Deputy Assistant Secretary for Financial Management
4/74-3/77	Deputy Assistant Secretary, Comptroller
1970-1974	Deputy Assistant Secretary, Budget
1969-1970	Director, Division of Budget, Office of the Secretary, DHEW
1968-1969	Director, Office of Financial Management, Health Services and Mental Health Administration, DHEW
1967-1968	Director of Finance, Public Health Service, DHEW
1965-1967	Chief, Financial Management Branch, National Institutes of Health, DHEW
1960-1965	Chief, Management Policy Branch, National Institutes of Health, DHEW
1958-1960	Assistant to Assistant Secretary for Administration, DHEW
1950-1958	Management Analyst, Social Security Administration, DHEW

NUMBER OF POSITIONS IN PHS

Senator ABDNOR. Thank you, Mr. Miller, for that very fine report. I realize you have a large organization and it would probably take days to go into detail. Looking at those figures, what is the total position level in the Department?

Mr. MILLER. Throughout the entire Public Health Service?

Senator ABDNOR. Yes.

Mr. MILLER. It's approximately 55,000 people, Mr. Chairman. That's the entire Public Health Service, not just the Office of the Assistant Secretary for Health.

Senator ABDNOR. They're in the field?

Mr. MILLER. Both in headquarters and in the field. The largest two headquarters components are the National Institutes of Health in Bethesda and the Centers for Disease Control in Atlanta. There are also large numbers of staff in the regions.

FEDERAL REGULATIONS

Senator ABDNOR. I have several questions. First, let me say I will ask several, and submit the remaining questions for the record.

Paperwork and regulations are on most people's minds these days. To what extent is the health care industry burdened by Federal paperwork?

Mr. MILLER. I don't know if I can quantify the extent to which the health industry is burdened. I did come prepared to brag a bit about what we have done to unburden it, because between the years 1975 and 1979 we have reduced by almost 2 million hours the amount of paperwork the public has to perform, which is roughly 43 percent in comparison to the forms they had to fill out in 1975.

We have a total of 136 existing regulations in the Public Health Service, only 9 in the Office of the Assistant Secretary for Health, and only in 1 instance, in the Food and Drug Administration, are we asking that we have an exemption from the President's current freeze on issuing regulations until the Office of Management and Budget has a chance to study them.

Senator ABDNOR. Could you repeat that? How much did you cut? Almost half?

Mr. MILLER. Forty-three percent, from the amount of hours that it took to fill out forms in 1975. We reduced that amount by 43 percent by 1979.

Senator ABDNOR. That was quite a remarkable savings.

Mr. MILLER. It was very conscious. It certainly is an effort which all of the officials in the Public Health Service supported including bureaucrats.

Senator ABDNOR. Members of Congress hear about the paperwork all the time. What is your best estimate of the cost of the Federal regulations to the health care industry?

Mr. MILLER. I'm sorry, Mr. Chairman. We can try to get that for the record. I don't even have an estimate.

[The information follows:]

COST OF PHS REGULATIONS TO THE HEALTH CARE INDUSTRY

The majority of Public Health Service regulations would not have a significant direct cost impact on the health care industry since these regulations are basically managerial in nature and relate to grant administration, management of PHS facilities, and medical care and examinations in PHS direct care programs.

Although the remaining regulations do have an impact on certain segments of the health care industry, it is very difficult to accurately estimate costs, due to lack of sufficient data and generally accepted standards for developing such estimates. In many instances, Federal regulatory requirements are similar to or the same as requirements imposed by other organizations such as the Joint Commission on Hospital Accreditation, thus making a cost estimate difficult.

REDUCING COSTS

Senator ABDNOR. Are you planning to cut costs further?

Mr. MILLER. To reduce paperwork?

Senator ABDNOR. Yes.

Mr. MILLER. Yes, we do; in fact, we have a target of reducing it 25 percent further.

Senator ABDNOR. That's the private health sector?

Mr. MILLER. It is the Federal burden on both the public and private sector.

Senator ABDNOR. Have you got any idea of what you can expect for a reduction—the impact it would have on the cost of health care from proposed or your future changes? Are you looking for a big savings both to the private health sector and your own department?

Mr. MILLER. Again, Mr. Chairman, I don't know that we can quantify a specific savings. I guess what we would hope is that the dollars that the Federal Government saved in reducing paperwork can be turned into dollars spent dealing with health problems rather than filling out forms.

Senator Abdnor. I would think, with that reduction, you must have seen some notable achievements in dollars and cents already.

Mr. Miller. We will try to provide for you as best we can some kind of dollar association with that reduction.

FINANCIAL ASSISTANCE TO HMO'S

Senator Abdnor. Mr. Miller, how many of the federally assisted health maintenance organizations have a good chance of continuing operations without Federal financing assistance?

Mr. Miller. Is your question those currently in operation, qualified HMO's?

Senator Abdnor. Yes.

Mr. Miller. May I ask Mr. Veit to give you an estimate on that?

Mr. Veit. Senator, it is difficult to come up with a precise answer to your question. A couple of facts. There are currently 118 federally qualified HMO's, and of those, approximately 41 are operational without any Federal loan moneys at all, and could continue to operate without any further Federal moneys.

Of the 77, that now operate with Federal loan moneys, 12 have already reached a point of financial health and are no longer dependent on Federal moneys, although they were at one point dependent on Federal moneys.

The remaining 65 HMO's are still dependent on Federal moneys, Federal loans, and it would only be speculation as to how many of those would be able to reach the breakeven, if they no longer have Federal moneys. We are currently projecting, however, that an additional 12 will reach this point in fiscal year 1981.

I would guess probably most of them are dependent on Federal loan moneys to reach breakeven.

Senator Abdnor. What makes the difference between those that are progressing satisfactorily and those that aren't? Are those which have been in operation longer more effective, or is it a matter of participants in the HMO's?

Mr. Veit. I think it would probably be helpful to divide those HMO's into three specific categories.

Category No. 1 would be the HMO that was sponsored by a nongovernmental organization, for instance, Blue Cross, a commercial insurance company, or a corporation. Those organizations typically do not come to the Federal Government for any financial support.

The second category would be an organization that has come to the Federal Government for support, for instance, an organization that is sponsored by a group of physicians, a group practice of physicians, or a consumer group, a community group that is unable to raise money in the private sector, and who has received Federal money, has reached breakeven, and no longer need Federal support.

The third category would be the same type of HMO that is community-sponsored program, physician-sponsored, or consumer-sponsored, that has no other source of private capital that does depend on the Federal Government.

Unfortunately, Senator, in previous years, private money to start HMO's had been relatively scarce. Now, I believe that that situation is changing with more insurance companies and Blue Cross organizations coming up with dollars to support HMO's. But the bulk of the ones that my office has been involved in have been organizations that have sought private funding but have been unsuccessful, so that they come to the Federal Government and we provide them with the money.

And they will, for the most part, Senator, continue to be dependent on Federal moneys until they do reach the point of breakeven.

STATUS OF QUALIFIED HMO'S

Senator ABDNOR. Basically, all of them are doing a good job. We don't have some operating that maybe are questionable, do we?

Mr. VEIT. Well, I think maybe there are some. There are some of the HMO's that have been funded by the Federal Government that are stronger than others. There are some weak ones. There are some that have had management problems that will undoubtedly not succeed; that will probably fail before they reach breakeven.

It would be hard to speculate on exactly what that number would be, but some of them will fail. HMO's operate as businesses. Some of which are managed well and succeed, and some of which are not managed well, and don't succeed.

Mr. MILLER. The appropriation, Mr. Chairman, includes—or the authority that the appropriation provides—includes a loan fund, which is designed to cover any of the HMO's which go into default status. The Federal Government must cover these defaults.

Senator ABDNOR. How many of the federally assisted qualified HMO's are currently not in compliance if a large financial sum is required?

Mr. VEIT. Of the 77 HMO's that are now operating with Federal loans there are—I would like to submit the exact number, Senator, if I may.

Senator ABDNOR. Please do.

Mr. VEIT. Of the 77 HMO's that are now operating with Federal loans, 23 are in noncompliance—3 additional HMO's operating without Federal loans are also in noncompliance—and there are an additional 20 that we are looking at very carefully relative to their financial situation.

I might just add, parenthetically, that HMO's are very, very difficult businesses to get started. They often run into difficulty. It doesn't necessarily mean that they won't ultimately succeed. But we find for the first couple of years we have to watch many of the HMO's very carefully, because they do tend to run into financial difficulty.

HMO DEVELOPMENT

Senator ABDNOR. Do you know of a number more that are coming on line or still being formed? Or are they pretty well in operation?

Also, do you see more HMO's coming into existence?

Mr. VEIT. There has certainly been an upward trend in the number of HMO's being started, over the last 3 or 4 years. The number of programs that we have qualified has increased dramatically in the last couple of years. We currently have 87 programs, that are developing with grant moneys, that are being supported by the Office of Health Maintenance Organizations.

So that's one category of programs that is not yet operational, but could conceivably come on line within the next couple of years. The number is somewhere in the eighties.

There are also, according to a survey that was conducted by my office within the last 6 months, about 120 HMO's that are being developed privately that are not, at the present time, at least, dependent on Federal moneys.

So the answer to your question is that there are about 120 privately funded HMO's developing, and somewhere around 87 HMO's that are developing with Federal moneys at the present time.

COMPLIANCE MONITORING

Senator ABDNOR. What is the Department strategy for dealing with financially unsound, federally assisted HMO's? Do you have a set program?

Mr. VEIT. Yes; we have. Over the last couple of years, we have implemented an elaborate program for closely monitoring the federally qualified HMO's. We have, in my office a division of HMO compliance. Each federally qualified HMO, whether they are federally funded or not, is required to submit periodic reports to my office, which tells us the status of their financial situation, and which also tells us about their utilization experience, and so forth.

Those reports are the key information that we have that lets us know if an HMO is starting to run into trouble financially. If we find an HMO is running into trouble financially, we conduct an evaluation. We actually go on site; we look at the books, we interview the board; we talk to the management, and if further action is needed, then we ask the HMO to submit a plan to us for returning to a state of compliance.

We also have technical assistance capabilities available to us, where we will send out experienced managers, HMO managers, to troubled programs, to help them rehabilitate themselves.

Senator ABDNOR. Have they had pretty good success with that? I mean, is it working?

Mr. VEIT. I would say we have had mixed success.

HMO INSOLVENCY

Senator ABDNOR. Considering that. Do you think the Federal Government should assume an increased responsibility to protect the members of failed plans? Are there some that just shouldn't be operating, and you go in there and say, "Look, it isn't working"?

Mr. VEIT. That's correct.

Senator ABDNOR. "It isn't feasible. The sooner we can close this out"—you have had some of that, too?

Mr. VEIT. Yes; I would say once the individuals on my staff go out and take a look at an HMO, sometimes, as a matter of fact, in 10 cases, we have made the decision that this HMO cannot be saved. It's either not well managed or it's ill-conceived, or whatever, and that we felt the HMO should be closed.

Another part of your question, which I think is very critical, is once the decision is made to close an HMO, to remove their Federal qualification, to make the decision not to provide them with any more funds, then what happens to the members of the plan, that is, the people who are enrolled members of the plan.

I do think that there should be something done to better protect the members of HMO's once they fail. The Department is currently in the process of looking at various options that could be submitted in legislation that would provide those safeguards.

Mr. MILLER. On that score, Senator, also, before the HMO that serves the population closes down, one of the strategies that we follow is to try to find another organization which is financially able to take over that population and provide them with the same service. That sometimes is the solution, rather than simply closing down HMO services entirely to that particular population.

Senator ABDNOR. Do we have pretty good success at that?

Mr. MILLER. We've had one in this city, where that exact situation occurred last year.

Mr. VEIT. I might just add briefly that we're finding there is increased interest on the part of Blue Cross and commercial insurance companies, in particular, to look at some of our troubled HMO's and to take over their management and operate them. We have had a fair amount of success with that in the last year or so.

NUMBER OF HMO'S AT BREAKEVEN POINT

Senator ABDNOR. How many HMO's that have received Federal assistance are now entirely supported by the private sector?

Mr. VEIT. The number, Senator, is about 12.

RURAL HMO'S

Senator ABDNOR. I come from a rural area of South Dakota. To what extent, if any, has private enterprise shown interest in establishing HMO's to serve rural, low-income, and medically underserved communities?

Mr. VEIT. Let me first talk about rural HMO's. We have funded 57 projects in rural areas since the beginning of our program, and some of those are currently developing as grantees. Ten of them have become federally qualified HMO's, and those 10 programs have received approximately $5 million in loan moneys to become operational.

Now we find that in the rural areas, the two most likely sponsors are either physicians in those areas or consumers in those areas. We've had relatively little interest on the part of insurance companies or corporations in rural areas. There have not been great numbers of successful ones.

As I say, the ones that have been developed and are successful are generally either consumer- or physician-sponsored programs that have come to us for support.

Senator ABDNOR. What's the very minimum you can ever hope to set up an HMO? I mean, you've got to have a certain amount of individuals involved, as well as physicians.

Mr. VEIT. That's right.

Senator ABDNOR. Much of what I call rural, under almost any condition would be able to——

Mr. VEIT. I think that's the best one of the reasons why there are so few HMO's that have developed in rural areas. You need a sizable population concentration for them to be able to become financially self-sustaining, although there have been such HMO's that have reached breakeven with as few as 4,000 or 5,000 members.

So I would say in an area that is very, very supportive of an HMO, an area that can draw on a total population of, let's say 10,000 or 15,000 people, there is some chance that an area like that could develop an HMO. If it were much smaller than that, it would be extremely difficult.

Senator ABDNOR. I understand some of your urban HMO's have rural satellites; is that right?

Mr. VEIT. That's correct.

Senator ABDNOR. Are they working?

Mr. VEIT. That tends to be a much better way to develop an HMO in the thinly populated area—have urban HMO's set up a satellite. There's a good example of that, for instance, in Albany, N.Y., where there's a very successful urban-based HMO which set up a satellite in a community 40 miles south of Albany, and that's working out really quite well.

CONTINUED FEDERAL SUPPORT IN HMO DEVELOPMENT

Senator ABDNOR. Why is it necessary for the Department to continue providing additional support to HMO's, particularly metropolitan HMO's? Aren't they able to sustain?

Mr. MILLER. I think this is an evolutionary matter, Mr. Chairman. I think the point we are all trying to determine is the point at which this program may have matured enough that it will not be necessary for the Federal Government to provide support to that kind of an HMO.

We are really at a very critical point in our evaluation of this program to see if we can maintain the kind of coverage which we believe is very beneficial, particularly from the standpoint of providing preventive health services we want to be sure that occurs before the program is turned over to the private sector.

But we believe that that evolutionary point is being reached, and the program is reaching a point where it probably can walk on its own.

REAGAN PROPOSALS REGARDING HMO'S

Senator ABDNOR. The Reagan proposal—I'm sure you read this very closely by this time—says the administration believes that after 8 years of Federal support, the feasibility of HMO prepaid health care delivery has been adequately demonstrated and that HMO's can be financially self-supporting institutions developed without continued Federal subsidy.

Would you care to comment on that?

Mr. MILLER. Yes, sir; as you noticed in the Reagan proposals, it is estimated that we will reach that final point in fiscal year 1983, and the Department still has under discussion with the Office of Management and Budget exactly what needs to be supported up to that point, through what means—meaning grants and/or loans. But that is the direction that we do want the program to move.

PRIVATE FUNDING FOR HMO'S

Senator ABDNOR. Along that line, in stimulating private funding of HMO's, what approaches to providing both tax incentives to HMO developers and easier access to Federal loan guarantees have been explored?

Mr. MILLER. I just mention briefly that there has always been a very close association between the Department, particularly the Office of Health Maintenance Organizations, and industry and labor, determining from them which kinds of Federal controls are burdensome and tend to set back the growth of HMO's and what kinds of stimulants they need. So there has been a constant dialog on that very point.

Mr. Veit may want to comment further, specifically what kinds of actions may be necessary to permit greater private development.

Mr. VEIT. We have explored both areas that you mentioned, Senator—tax incentive options as well as easier access to the loan guarantee. These options are currently being discussed by our Office's Industry Council made up of some key business and labor people. And I think we don't yet have any specific answers.

One of the things that industry does state to us that is a comment that's made in the policy statement that OMB has come out with on HMO's, is that industry does want us to begin to look at the regulations and the requirements on HMO's. There are a number of people out in the private sector that argue that if we reduce some of the requirements on HMO's—benefits, community rating, some of those questions—it would act as an incentive to get more private interest in developing HMO's.

Loan guarantees have been mentioned, but we don't have what I would call a very specific proposal on that nor do we on tax incentives.

Senator ABDNOR. That's something you'll be looking at?

Mr. VEIT. Yes; it is something that should be looked at, and we will be looking at it.

PUBLIC AWARENESS

Senator ABDNOR. In September 1979, the Department of Health and Human Services funded the development of television ads along with print or radio ads for the promotion of health maintenance organizations. Time and space to run the ads were to be paid for by local HMO's. Has that been utilized much in the communities?

Mr. VEIT. You are referring to an advertising campaign that was conducted in the Chicago area last summer. The Department financed the development of some materials that were shown on television, ran on air time on the radio, and in the newspapers and so forth.

Our objective was to attempt to see whether we could increase the awareness of the population in the metropolitan area relative to the advantages of HMO's. The Department developed the materials, and the HMO's in Chicago—I believe there are six of them that participated—bought the air time and the space to actually run the materials that we developed.

That did take place, as I said, over the last summer. We have done a followup study and have shown that the level of awareness on the part of the people in the Chicago area has increased quite markedly as a result. Several of the HMO's claim that it was of significant help to them in terms of their enrollment of members as well.

Senator ABDNOR. While that was going on, the HMO's, the companies themselves, were offering incentives in enrollment. That was part of it, too. You attribute the awareness and the new enrollees in the companies—can that be attributed be much——

Mr. VEIT. It's very difficult to make a specific cause and effect. What we do know is, the enrollment curves in several of the HMO's went up after the advertising campaign. How much of the increase was a result of the advertising campaign it would be very difficult to say, particularly since in the city of Chicago last year, the city employees were offered HMO's for the first time. So the cause and effect is difficult to draw a linkage between.

Senator ABDNOR. You said some of the costs were borne by the local HMO's. How much did the entire program cost?

Mr. VEIT. I believe—again, I would be very happy to submit that for the record.

Senator ABDNOR. Please do.

[The information follows:]

PUBLIC AWARENESS CAMPAIGN IN CHICAGO

The total cost for the public awareness campaign in Chicago was $319,000. A total of $179,000 in Federal funds was used for the development and testing of commercials and print advertisements: production of materials: and market research. The remaining $140,000 was contributed by the six participating HMO's and was used to pay for the campaign's advertising. No Federal funds were spent for advertising.

COST PER ENROLLMENT

Mr. VEIT. I believe the Federal Government's cost was about $200,000 and HMO's somewhere around the same amount. I will have to submit that for the record. I don't have it right at my fingertips.

Senator ABDNOR. While you are doing that, Mr. Veit, can you give us the unit cost per increased enrollment, too, so we'll have some idea from this end how it looks per capita?

Mr. VEIT. Yes, sir.

[The information follows:]

RESULTS OF PUBLIC AWARENESS CAMPAIGN

Measurement of the results of the campaign revealed that awareness of HMO's increased among the general public by 50 percent, based on a comparison of precampaign knowledge with postcampaign knowledge. Among the consumer group toward which the campaign specifically targeted its coverage—25 to 49 year olds with children residing at home and total household incomes of $25,000 or more—awareness increased 267 percent. Most importantly, compared to the same period of time in the previous year, the rate of enrollment in Chicago HMO's for the period from June to September 1980 was up to 55 percent.

Despite the fact that we can measure these items, as stated previously, it is very difficult to make a direct link between the increased enrollment and the advertising campaign. Therefore, it is not possible to provide the unit cost figures that have been requested.

HEALTH CARE TECHNOLOGY

Senator ABDNOR. It's been suggested that costly medical equipment could be better utilized and lives saved if a clearinghouse existed that noted the location of equipment. Contractual agreements could be made to share health facilities in the same geographical area.

To what extent does the National Center for Health Care Technology serve as a clearinghouse to facilitate technology and equipment sharing by health care facilities in the same geographical area?

Mrs. HANFT. The National Center does not serve as a clearinghouse per se. The role of the National Center is to perform assessments of the technology and make that information widely known to providers and consumers and the health industry itself. We do that through a variety of mechanism including the National Library of Medicine, the medical literature analysis and retrieval system, publications such as the Journal of the American Medical Association, in terms of specific technology.

The Center is very small and does not have funds to operate a clearinghouse.

Senator ABDNOR. How long have you been working in that area?

Mrs. HANFT. The Center has been operating about 2 years, and if you will note, the budget until this fiscal year has been about $3 million, and it's been a very small operation just getting started.

Senator ABDNOR. Do you feel it can accomplish a worthy purpose?

Mrs. HANFT. It can, given time and expertise and resources.

Senator ABDNOR. Do we have a clearinghouse that is in existence?

Mrs. HANFT. There is no clearinghouse on technology. We do a few things that contribute to that development. For example, each year we survey emerging technologies, and we make that list of new technologies that are coming onstream. We provide public information so that the general public and the providers and the consumer knows what is about to come out in the medical technology field.

We also assess specific technologies, particularly some of the complicated new technologies.

Senator ABDNOR. You do think there is a need for that, right?

Mrs. HANFT. There is a need for information for both providers and consumers. There are a lot of technologies out there, and not all of them have been assessed or will be assessed in the near future.

Senator ABDNOR. If you had to, could you assume that job?

Mrs. HANFT. That's a major job, because you not only have the newly emerging technologies, but we have technologies that we have been using for many years where the safety and efficacy have not been truly tested.

Now we have in this last year looked at a very large number of technologies and made some findings on those particular technologies—over 40 such technologies in the last year.

Senator ABDNOR. We have been joined by Senator Specter. We welcome you, Senator.

Senator SPECTER. Thank you.

ADOLESCENT PREGNANCY PROGRAMS

Senator ABDNOR. Are there any studies that compare the health outcome of teenagers and their babies that have participated in a comprehensive adolescent pregnancy program with those who have not?

Mr. MILLER. If Dr. Hutchins knows an additional answer to this, I'll ask him to talk to it. We are currently—we have just recently awarded an evaluation contract, for that program, which is really only in its second year of operation, which will be looking into exactly that kind of question, as to what the impact of that kind of counseling and work has on a population that receives it, versus one that doesn't.

I doubt that we have any definitive data on that, but let me ask Dr. Hutchins.

Senator ABDNOR. Are you going to be carrying that study on in various parts of the country, or in one local area?

Mr. MILLER. Certainly the sample they're going to take will be one that extends throughout the Nation. How many locations, I don't know.

Senator ABDNOR. Dr. Hutchins?

Dr. HUTCHINS. Yes; I think that's accurate. In addition to that, there have been individual projects around the country that have provided services on a demonstration basis to these kinds of patients before, and have found that they have had a decrease of morbidity with infants.

Senator ABDNOR. Along that line, could you tell me how the rate of repeat pregnancies of teenagers who have participated in a comprehensive program compares with those who have not?

Dr. HUTCHINS. With this program, we're not in a position to say that. Studies haven't been made of individual programs that have looked at that. Although the repeat rate of pregnancies has decreased somewhat, it has been found that services are needed over a longer period of time than was usually anticipated.

Senator ABDNOR. Those would be very interesting statistics to have.

Dr. HUTCHINS. We can provide that to you on an individual project basis from the past studies that have been done.

Mr. MILLER. As soon as the evaluation is completed, Senator, we will be glad to provide the committee with a copy.

Senator ABDNOR. Will that be quite a ways down the road?

Mr. MILLER. I think it's scheduled to be completed in August.

Dr. HUTCHINS. That's correct.

OFFICE OF ADOLESCENT PREGNANCY PROGRAMS SERVICES

Senator ABDNOR. That's fine. I'm sure the committee would be happy to have those figures.

Several programs in the Department devote significant resources to health and family planning services, directly to teenagers. What does the Office of Adolescent Pregnancy Programs do that could not be carried out by other health programs, such as the maternal and child health program, or the family planning program?

Mr. MILLER. I will speak to that first, Mr. Chairman, and then ask Dr. Hutchins. By chance, Dr. Hutchins, who is the acting director of this program, also happens to be the director of the maternal and child health program in the Health Services Administration.

I think what this legislation envisioned that was different than any of the other categorical programs was that it would span the full spectrum of matters that adolescents have to deal with that pertain to unwanted pregnancies, and it includes work in the education field as well as in the health.

So it does provide the kind of authority which enables us to put together moneys in a whole series of areas which no one of the other programs can do. I don't know whether Dr. Hutchins wants to add or maybe subtract from that.

Senator ABDNOR. Is there anything that can be done to coordinate these activities? Service activities? We were talking about carrying out the maternal and child health program, and the family planning program. Is there anything that you think can be done to coordinate these service activities?

Dr. HUTCHINS. In the Office of Adolescent Pregnancy, we're working with the unit programs to coordinate these activities. In further answer to the question you asked previously, that Mr. Miller answered, the adolescent pregnancy program project does not provide services of this kind if there are other entities in the community that are providing, but act as a referral to them.

Senator ABDNOR. You're not overlapping?

Dr. HUTCHINS. The intent is to coordinate them at the local level so that there is no overlapping.

Mr. MILLER. There is a formal interdepartmental group that is chaired by the head of this office, and includes not only the other programs of the Public Health Service that deal with adolescents, but also the Office of Human Development Services.

So there is a formal mechanism for trying to prevent overlap in these programs.

OFFICE ON SMOKING AND HEALTH

Senator ABDNOR. We're jumping around here. But we have a lot of questions. Let's just touch briefly on smoking and health. The Office of Smoking and Health reports that all indicators of cigarette smoking have been going down for the last 5 years, with the exception of women age 17 to 24. What is being done, and what can be done, about the substantial increase in the rates of smoking among the young women?

Mr. MILLER. Of course, the first and obvious answer to your question, Senator, is in the field of health education, which is an area that we do emphasize heavily in this program. And we try as best we can to educate youngsters about the consequences of smoking, without doing it with a heavy hand or any kind of compulsory——

Senator ABDNOR. Do you think you're really penetrating that age group?

Mr. MILLER. I'm fairly certain that the answer to that is, "Yes," but I would like Mr. Pinney, who is the head of the Office on Smoking and Health, to comment.

Mr. PINNEY. Mr. Chairman, I think with respect to that, I think the group of young women age 17, really, through 24, the message is getting through, but we're not sure that we have put it in the right terms to effect a change in behavior. The percentage of all people in this country, but particularly young people, who understand the general risks of smoking, has been going up steadily since 1964.

But it is, as you noted, in that particular age group of women, that we're still having a problem. We're attempting through behavioral research which the Department has made much greater investment in in the last 3 years, to understand more about why young women are taking up smoking, and why they persist.

Also, through more targeted public information and education efforts to reach young women in a way that they can personalize the information—and we hope to reach them.

SAFE CIGARETTES

Senator ABDNOR. There's a lot of talk about the safe cigarettes and advertising to that effect, too. I wonder, do you think efforts to develop a safe cigarette and the publications on the safe cigarette are having any effect on incidence of smoking in this group, or all other groups, for that matter. Maybe I should ask, Do you really think there is a safe cigarette?

Mr. PINNEY. I professionally and personally don't believe there is such a thing, and the Surgeon General, when he released the most recent report to Congress, indicated he also believed there was no such thing as a safe cigarette. We feel for those people who absolutely cannot quit; they are better advised to smoke a lower tar and nicotine cigarette. We found, however, that many smokers compensate for the change in tar and nicotine levels by smoking more, or inhaling more deeply.

And the limited evidence we have indicates that may negate the benefit of shifting to a lower tar. The only real benefit we've seen in any studies that are available is that there appears to be a reduced risk of lung cancer for those who shift to a lower tar cigarette.

Senator ABDNOR. The report that just recently came out—that was recently, wasn't it?

Mr. PINNEY. Yes, sir.

Senator ABDNOR. That was the first time we made a comment to the effect that there really wasn't that much proven of the safe cigarette, if there was such a thing. I suppose that could have well been a thought that harbored in the minds of younger people, thinking that they can smoke—if they smoke the safe cigarette.

Mr. PINNEY. One of the interesting facts about teenage smoking, unfortunately, Mr. Chairman, is that the younger teenagers seem to choose the higher tar, more widely advertised brands to start with. Whether that's an effect of peer pressure or their response to advertising, we don't know.

But the more popular brands seem to be the brand of choice for young people. By the time they reach about the age of 20 to 21, then they begin to have brand choice patterns that look more and more like their adult counterparts.

HEALTH EDUCATION

Senator ABDNOR. There are numerous programs in the Department of Health and Human Services providing health education services. Still, all these various agencies are putting money into programs for health education. Why not set up a separate bureau to administer them in a more coordinated, cost-effective manner?

Mr. MILLER. Yes; I'll comment on that, Senator. The function is such an important one, including, I would say, programs of virtually all of the six agencies of the Public Health Service, that I would not think it was a good idea to take from them their responsibilities for health education and health promotion.

I would strongly favor leaving those functions that the agencies have with them. However, it is important that there be a central point to determine what our priorities should be in the field, and to coordinate activities which cut across the agencies.

And indeed, we do have such an office, which is the Office of Health Information and Health Promotion, which Dr. McGinnis heads.

Senator ABDNOR. You would agree, wouldn't you, that there could be a considerable savings in dollars if the existing health educational programs were consolidated?

Mr. MILLER. I would agree, there should be savings through better coordination; we have to be very careful that there is no overlap or overkill. But I'm not sure that a stronger central organization would be the answer to achieving savings.

Senator ABDNOR. Approaching this question from the States' perspective it seems there certainly would be some savings from having to deal with only one Federal bureau instead of numerous agencies.

Mr. MILLER. I think the States ought to be able to come to one central point; yes. But that could be a coordinating point, because it would be, I think, impossible for the Alcohol, Drug Abuse, and Mental Health Administration not to retain the significant share of its health education and health promotional work. The professionals, who understand the field, and who really ought to know how to communicate, are located there.

Senator ABDNOR. Do you have any idea, Mr. Miller, how much the States are spending for health education programs?

Mr. MILLER. How much the States are spending?

Senator ABDNOR. Yes.

Mr. MILLER. I don't know. Dr. McGinnis may. We can try to obtain that. Whether that's an obtainable statistic, I don't know. But we will try.

Senator ABDNOR. They don't have any one——

Mr. MILLER. Certainly, far more than the Federal Government.

FUNDING OF HEALTH EDUCATION BY STATES

Senator ABDNOR. What State matching requirements exist for the current federally funded health education programs?

Dr. MCGINNIS. Mr. Chairman, there are no Federal or State matching requirements, to my knowledge, that exist for programs in health education. There is a risk-reduction grant program which is primarily devoted to health education activities administered by the Center for Disease Control, to provide funds for the activities of States and their geopolitical subunits in health education and lifestyle-related activities. But it's not offered on a matching basis.

Senator ABDNOR. Do you think the States can assume more responsibility for a greater share of the funding?

Are States in a position to take over more of the cost of education programs?

Dr. McGINNIS. I think that's very difficult to say at this point. Clearly, the States at various points in time throughout the last several years have expressed interest in additional Federal contributions to the area; hence, the risk-reduction grant program.

Whether the States are in a position, now, to assume a greater responsibility, is something we will have to see over time.

Senator ABDNOR. Let's see: You said there was no requirement now on the part of the States to match the moneys?

Dr. McGINNIS. To my knowledge, there is no matching requirement to the States for the risk-reduction grant program.

Mr. MILLER. I would like to add to any data that we provide for the record, Mr. Chairman, an estimate of the amount of Federal money that is spent by the Public Health Service on health education activities. This is not a major item of cost in the budget.

On the other hand, it is targeted primarily to preventive activities, which we think in the end yield the greatest cost savings. But I would like the record to indicate how much the Public Health Service spends. It's a small item, of course, compared to other health costs.

[The information follows:]

FUNDING FOR HEALTH EDUCATION

The Public Health Service provides health education activities through designated programs in the Office of the Assistant Secretary for Health and other agencies of the PHS. Except for some selected programs, health education efforts are difficult to distinguish from other elements of a program which provide information or respond to public inquiries. For purposes of this response, health education activities within OASH will be described as these program activities which have been explicitly identified in the past as health education related.

The health education risk-reduction grants administered by CDC represent a primary example of an educational program addressed specifically to disease prevention and the promotion of better health. The program is directed principally to six risk factors which relate directly to personal behavior choices: smoking, abuse of alcohol, obesity, fitness, hypertension, and stress management. It is designed to build the capacity of the States to stimulate, monitor, and evaluate such programs, and to support a limited number of intervention projects carried out by local agencies. Grants under this program totaled $3.6 million in fiscal year 1979 and $6 million in 1980. Over and above these figures, the $10 million grant program to support local programs to deter smoking and the use of alcohol among children and adolescents, authorized under section 402(a)(2) of the Public Health Service Act, is also administered through this program and the State health education risk-reduction grantees. A total of 130 such projects under a wide variety of local auspices were funded in fiscal year 1980: more than half of which were conducted in school systems, and nearly one-third addressed to minority groups.

In the OASH the Office of Disease Prevention and Health Promotion has spent approximately $347,000 in fiscal year 1979 and $313,000 in fiscal year 1980 for health education activities. In addition the Office has funded the national health promotion media campaign, which is a multimedia campaign to introduce the concept of relative risk and personal control over health status through choices that contribute to a healthier lifestyle. Approximately $200,000 in fiscal year 1979 and $218,000 in fiscal year 1980 has gone toward the media campaign. This media activity, through which is woven health education and health information dissemination efforts, is an example of how difficult it is to differentiate between these two program elements. Also, within the OASH, the Office on Smoking and Health has indicated health education expenditures at $300,000 in fiscal year 1979 and $750,000 in fiscal year 1980 for the development and dissemination of public information materials.

Throughout the PHS there are approximately $110 million in specific health education activities. Additionally other educational information is provided by programs within the PHS that have not been explicitly identified as health education programs.

PROGRAM INPUT BY STATES

Senator ABDNOR. Do the States have much input regarding what goes into the program?

Mr. MILLER. A lot of our education dollars are targeted toward all populations, including States, to persuade them to conduct the educational efforts. And we don't try to control the manner or even the substance of what they do. We provide them with materials that we hope would be useful.

But we don't attempt to control their methods of education.

Senator ABDNOR. So what's being done now in the program is pretty much the choice of the States?

Dr. MCGINNIS. That's correct; one of the watchwords in administering the grants has been allowing maximum flexibility for creative program activity within a certain set of activities. Some priorities are specified, for example, smoking and health, or alcohol among youth, and so forth. But within general priority guidelines, we encourage flexibility at the State and local level for program formulation.

Senator ABDNOR. You have a chance to observe. Is there quite a difference from State to State in the programs? And also, maybe the success of them.

Dr. MCGINNIS. One would expect a difference from State to State, given the fact that there are differences in priorities that various States have. And there are differences in approaches.

For example, some States have chosen to link up with other States in developing regional consortiums for health promotion and education activities. Other States have chosen to rely more on internal units within the State, county-based activities for their activities. There has been a fair amount of difference from State to State.

Senator ABDNOR. Are the subjects they cover pretty common, like family planning? Is that pretty general in all States?

Dr. MCGINNIS. The subjects are frequently similar because there are some clear priorities that are similar.

For example, you just mentioned smoking. Smoking is the single most important preventable cause of death in the country. Clearly, then, each of the States places smoking as a high priority, and we try to do what we can through the Office on Smoking and Health and other programs in the Department to insure information sharing between States and the activities that go on. In effect, we try to use these programs as ways of reducing duplication of effort as the States try to provide information to their citizens.

Senator ABDNOR. Senator Specter?

Senator SPECTER. Thank you, Mr. Chairman.

Mr. Miller, I note you are a Philadelphian.

Mr. MILLER. I am; I confess.

Senator SPECTER. I see your résumé, and it's nice to see a fellow Philadelphian here today.

PRESIDENT REAGAN'S NEW PROPOSALS

I would like to ask some questions with respect to the budget as it may be affected by what President Reagan's new proposals may have in mind.

Do you know with any precision what President Reagan's proposals are going to be for 1981–82?

Mr. MILLER. I know with a substantial degree of precision; yes. The process is reaching its culmination now. It's followed the normal budget process. We have been requested to make a number of proposals for cuts, and we received a number of proposals which were generated by the Office of Management and Budget. We have given our reactions to the Office of the Secretary, and they in turn determine which ones to discuss with the Office of Management and Budget.

Senator SPECTER. There are no 1982 figures on the sheets which I have before me. Is that because none have been sent in?

Mr. MILLER. That's right. As I understand it, the 1982 figures will be sent to the Congress on March 10.

Senator SPECTER. So that it's really meaningless to take a look at the fiscal year 1982 budget request which was submitted by President Carter.

Mr. MILLER. Yes; I would say so.

PHASEOUT OF HMO PROGRAM

Senator SPECTER. Is it true that the health maintenance organizations are to be phased out over a 3-year period?

Mr. MILLER. The proposals that the President submitted to the Congress, along with his economic message last week, indicate that that is the administration's policy. We still have parts of that policy under discussion with the Office of Management and Budget, particularly what mechanism—what kinds of grant and loan funding will be put together targeted toward that policy.

Senator SPECTER. What discussions have you had, if any, with anybody from Mr. Stockman's organization?

Mr. MILLER. I have not had any discussions with anyone from the Office of Management and Budget.

Senator SPECTER. With whom have you had discussions about revisions of budget figures for 1981 and figures for 1982?

Mr. MILLER. We've had extensive discussions within the Public Health Service, with the six operating agencies of the Public Health Service, and also with the Office of the Secretary, including the budget staff and the Under Secretary.

Senator SPECTER. And what is your response to the proposal to eliminate the health maintenance organizations over a 3-year period?

Mr. MILLER. Well, as we discussed earlier when we were discussing the health maintenance organizations, certainly if we can make this effort continue on under private auspices and if the Federal Government has played its proper role, I think the question is one of when the private sector is ready to take over.

Senator SPECTER. Are the items which are listed under the category of "Health initiatives" to be taken care of in block grants, as you understand it, as opposed to the specific categories of "Adolescent health services," et cetera?

Mr. MILLER. The only program in the Office of the Assistant Secretary of Health that is to be included in the block grant is the adolescent pregnancy program.

Senator SPECTER. And the rest of these programs are to be maintained as categorical programs?

Mr. MILLER. Yes.

PROPOSED CUTS FOR FISCAL YEAR 1981

Senator SPECTER. Do you anticipate that there will be cuts proposed for fiscal year 1981 yet?

Mr. MILLER. Mr. Chairman, if I may—I don't want to anticipate. With your indulgence, I would prefer not to speculate on that until the March 10 budget comes out.

Senator SPECTER. The March 10 budget, is that going to deal with 1981 as well as 1982?

Mr. MILLER. Yes, it will.

Senator SPECTER. So that the realities are that it's pretty hard for the subcommittee to deal with these subjects until we really know your March 10 figures.

Mr. MILLER. That's true in terms of the 1982 budget. I had understood the primary purpose of these hearings was as an oversight and overview of our current programs.

Senator SPECTER. You're also expecting some changes in the 1981 budget?

Mr. MILLER. Yes.

ASSISTANT SECRETARY FOR HEALTH/SURGEON GENERAL

Senator SPECTER. On this table of organization, the position is Assistant Secretary for Health and Surgeon General/Public Health Service?

Mr. MILLER. Yes.

Senator SPECTER. Are the newspaper accounts correct that Dr. Koop is going to be the new Surgeon General?

Mr. MILLER. My understanding is that legislation will be submitted to Congress to permit Dr. Koop to be the Surgeon General. His age is such that Congress would have to change the legislation in order for him to assume that post.

Senator SPECTER. Would he have the position of Assistant Secretary for Health?

Mr. MILLER. No; my understanding is, he would be the Deputy Assistant Secretary for Health and Surgeon General. Dr. Brandt would be the Assistant Secretary for Health.

Senator SPECTER. So that structural change would be a deviation from the way the position has been occupied heretofore?

Mr. MILLER. Yes, it would; but this is the first time the position has been occupied with one person as both Assistant Secretary for Health and Surgeon General.

Senator SPECTER. Mr. Chairman, I would like to pursue one more line of questions, if I may.

Senator ABDNOR. Certainly. Please proceed.

LOW-TAR CIGARETTES

Senator SPECTER. That is with respect to the issue which you had discussed as to the lower rate of tar, if I might address a few questions to that subject matter.

I believe your testimony was that a lower rate of tar had shown some beneficial effects as to the results of your studies?

Mr. PINNEY. Only for lung cancer, Senator. The one or two major population studies that are available focused on lung cancer. They indicated that there was a modest reduction in mortality from lung cancer for people who smoke lower tar cigarettes.

The problem with those studies is that they do not deal with the cigarettes that are now being sold. The latest one was completed in 1972, and there's been no new data on a large scale collected since then which would give us an indication of what risks current cigarettes may pose.

But smoking is a dose/response relationship. The more tar, the higher the risk; the longer you smoke, the greater the risk. The relationship holds up in most of the major studies. With respect to lung cancer, there thus appears to be some reduction in risk, but the risk is still so much greater than that for a nonsmoker that our advice obviously is still to quit.

Senator SPECTER. When you say the tar has an effect as to lung cancer, the risk of lung cancer, what are the risks that were analyzed besides the risk of lung cancer?

Mr. PINNEY. We've looked at the risk of heart disease, cardiovascular disease. These studies do show some changes in mortality risk, but we felt and the group of scientists who reviewed the evidence felt there was insufficient evidence to draw as firm a conclusion. We also found this to be true with respect to lung diseases other than lung cancer. With respect to effects on the unborn fetus, there was not sufficient evidence to make any kind of a formal judgment about reduced risks.

NONHARMFUL SMOKING LEVEL

Senator SPECTER. Is there any level of smoking at all, say even a cigarette a day, which would be considered to be nonharmful?

Mr. PINNEY. In our judgment; no, sir. And the reason that I say that is, the variations in individual smoking patterns, the type of cigarette, and even the contents of the cigarette are all variables that are tied to the risk of disease.

For example, with pulmonary diseases like emphysema, we still don't understand what aspects of cigarette smoking, what type of smoking behavior contributed to the development of those diseases. So it would be totally unwise and unfounded to say any level of smoking was safe.

Senator SPECTER. What is the lowest level of smoking that your tests comprehended? Have you had tests, for example, which comprehended as little as one cigarette a day?

Mr. PINNEY. We have some population studies, Senator, that deal with people that smoke as low as five or less. But the problem with most of these studies is, we need a very large population base. The largest that has ever been done was the American Cancer Society volunteer study of 1 million people over a period of some 15 to 20 years. There are no studies like that in existence now, so we don't have the ability to measure those kinds of subtle differences.

Senator SPECTER. So it's a matter where you cannot say it's safe to smoke a cigarette a day, nor can you say that your studies have shown that as little as one cigarette a day or two cigarettes a day would have a harmful effect as to lung cancer or heart disease.

Mr. PINNEY. It certainly would be impossible to say there is no effect. It's reasonable to say that for some people there could be some effect at any level of smoking.

Senator SPECTER. Why do you say it would be impossible to say there's no effect?

Mr. PINNEY. The latency period, the period over which these diseases are developed would have to cover a period in which an individual smoked a fairly consistent pattern and smoked the same kind of brand for us to reach those conclusions.

The cigarette has changed so drastically in the last 20 years that no study embraces when an individual might have started with a cigarette of 1 milligram of tar and smoked that cigarette for 20 years. We have lung cancer cases, for example, being diagnosed now which are generally among men and women who started their smoking 25, 30, 35 years ago and who smoked cigarettes that range around 35 milligrams of tar. However, many of them may have changed their smoking by changing brand and changing the pattern of smoking over that period of time.

We have no studies where we could track someone from the onset of smoking with brand A with a known level of tar and nicotine to the onset of disease.

EFFECTS OF MINIMAL SMOKING

Senator SPECTER. I can understand your testimony where you are saying you have tracked people for a long period of time and found evidence which supports smoking does lead to lung cancer, for example. What I don't understand from your testimony is your statement that the evidence supports a conclusion that even a minimum amount of smoking produces lung cancer.

I would think the conclusion would be, you just don't have studies that show that one way or another, from what you said.

Mr. PINNEY. The judgment, Senator, of all the scientists who reviewed the evidence that is available is that there is no threshold effect. I think you're talking about a threshold effect, some determinable number.

One of the reasons is that there are some variables involved. If I were to smoke one Camel a day at 25 to 35 milligrams, that might be very different in terms of the risk that I was facing or someone who was smoking another brand with a lower tar and nicotine level. We're dealing now with 176 different brands of cigarettes on the market in this country. We're dealing with a range of substances that are added. We have no way of reporting to the Congress the effects of these additives on the health of the Nation, so we don't know what they are.

Senator SPECTER. Doesn't that all lead to the conclusion that you don't know, as opposed to the fact that you do know a minimal amount of smoking that is harmful?

Mr. PINNEY. We do know that a minimal amount of smoking is harmful. Finding that "minimal" is the difficulty, and I think it would be inappropriate from a public health point of view to attempt to define the minimum for a population of 54 million smokers, each with his or her own smoking pattern, each with a brand history and a lifetime history of smoking, and a different exposure rate.

It's a very complicated scientific problem in terms of determining the actual dosage that I or you as a smoker might have accumulated over a lifetime of smoking. So that to say that one cigarette a day for someone who never smoked, if they did it with brand X at this rating and took only a 35 milliliter puff volume and smoked for 20 years might in fact result in no harm to them would be a fairly complicated public health message.

Senator SPECTER. Would it be accurate?

Mr. PINNEY. I don't believe we could get that accurate now. As a matter of fact, I know we couldn't get that accurate, and I think the real confounding variable now is that we don't know what's in the cigarette besides tobacco, and we have no control over what goes into it, nor do we have any way of finding out what goes into it.

Senator SPECTER. Thank you very much. Thank you, Mr. Chairman.

RESEARCH ON NATIONAL HEALTH INSURANCE

Senator ABDNOR. Mr. Miller, the budget narrative indicates that the National Center for Health Services Research is planning research on various national health insurance proposals. I think it's safe to say that national health insurance appears to be a dead issue.

Why is this kind of research necessary?

Mr. MILLER. I will ask Mrs. Hanft to comment on that. I think this kind of research leads to benefits that are far beyond a specific legislative proposal for national health insurance. I think the research tells us a great deal about what kinds of benefits yield the greatest results and a whole variety of things that we need to know in the health services field that go beyond the simple question of whether there should or should not be legislation.

Senator ABDNOR. Does that include facts for national health insurance or should it be corrected in some other way?

Mrs. HANFT. May I clarify that? A major study was undertaken in 1977 called "National Medical Care Use and Expenditures Survey." That is a survey that covers a number of items such as insurance coverage, changes in medicaid status of certain population groups, use of services, the demand for services. The only reason the budget justification said what it said was, that the Carter administration was contemplating a national health insurance program, and the data from that survey would have been useful in modeling different proposals.

For example, the data collected in there would be very useful in looking at catastrophic health insurance proposals, because we did not have data on catastrophic illness and catastrophic costs and how it distributes over the population. The data are not primarily for the purpose of national health insurance modeling but are useful for such a model, as well as useful to let you know what happens with the medicaid population, what happens with the medicare population, what the physician's role is in the demand for services, and for example veterans' insurance coverage.

Senator ABDNOR. How much money is budgeted for that in 1981 and 1982?

Mrs. HANFT. Only for some analysis, and it's only about $200,000 for the analysis of the survey that's been completed.

RAND CORP. STUDY

Senator ABDNOR. I believe the Rand Corp. was, and maybe still is, conducting an experimental health insurance demonstration program in a number of areas of the country. What's the status of this project, how much has been spent to date and what have we learned from it?

Mrs. HANFT. I'm afraid the Department will have to answer that question. That was a survey being conducted out of the Office of the Secretary.

Mr. ITTEILAG. Mr. Chairman, that project is conducted by the Rand Corp. for the Department's Office of Planning and Evaluation. The health insurance experiment is a research project, not a demonstration, conducted by the Rand Corp. under a grant. It is designed to address health policy issues generally, not just national health insurance. In particular, it addresses several issues directly relevant to current legislative proposals with respect to competition and consumer choice. Up through fiscal year 1981, $63,200,000 will have been spent on this project.

Most of the experimental participants have already exited from the study. The 5-year samples in Seattle, Wash., and in Franklin County and Fitchburg, Mass., will exit in September 1981. The last participants, in Georgetown County and Charleston, S.C., will exit in January 1982. Data collection and processing will extend into fiscal year 1983. The major analyses should be completed by 1984. However, the rich data base will probably be used for studies by different research groups for several more years.

Results of the nonexperimental analysis of the impact of costsharing on demand for health care are used in the Department's health care financing model to estimate costs of various health care financing proposals. Interim results, based on the analysis of aggregate annual expenditures for 9 site-years of data show that those fully covered for medical services spend around 50 percent more than those who pay for all costs up to an income related maximum out-of-pocket expenditure. Full coverage leads to both more users and greater consumption per user for both ambulatory services and the number of hospital admissions. Once patients have been admitted to the hospital, however, expenditures per person do not differ significantly among the experimental insurance plans. Nor does the probability of hospital admission for children vary by insurance plan. Variation in costsharing affects adults total expenditures more than children.

Further analysis is required to determine the relationship between actual expenditures, quality of care received, and the effect on health status. Also the effect of a health maintenance organization on utilization and health status in comparison with fee-for-service plans will be examined when data collection and processing is completed.

RESULTS OF HEALTH SERVICES RESEARCH

Senator ABDNOR. Where are we going from there?

Let me ask you this question. To what extent has research sponsored by the National Center for Health Services Research during the last 3 years led to changes in health care policies?

Mrs. HANFT. There are a number of areas where the data on health services research have been useful. For example, the Congressional Budget Office has used our information on catastrophic illness data. The rural health care clinics and the use of nurse practitioners in those rural clinics came out of studies at the National Center for Health Services Research.

A very recent study has just shown the impact of regulation on prices for optometry services and show that by and large in the States where there is heavy regulation of this profession, the prices to the consumer are higher than in States where there is less regulation—very important in terms of States planning their own programs.

There are a whole series of studies related to computer technology. For example, the State of California is beginning to implement in its public hospitals and clinics the medical information system that was developed out at the National Center for Health Services Research. This is information on the clinic patients, on medical care. It helps monitor the programs, and it helps, of course, to look at the diagnosis and treatment of different patients.

There has been much work in the area of hospital medical information systems which have been developed—adopted by hospitals to create more efficiency internally, and as I mentioned earlier the national medical care expenditure survey is being widely used by the Department because for the first time it shows you the volatility of the medicaid population, how that population comes in and out of the medicaid program—the first time those data have been available for planning purposes.

There are a whole series of studies that I could continue discussing.

Senator ABDNOR. In other words, the savings have been pretty substantial.

Mrs. HANFT. I believe so. I can't quantify them, but certainly the use of nurse practitioners and telecommunications in rural areas has had major impact on the delivery of services and their costs in those areas.

COST CONTAINMENT

Senator ABDNOR. Thank you. How does the National Center for Health Services and Research implement its recommendations to help control the cost of health programs?

Mrs. HANFT. We can't implement anything. The only thing we can do is make our findings widely known to States and local governments, to provide information from the Federal Government, and to assist them in getting the kind of data and information they need for policy analysis and policy formulation. We don't actually implement programs, other than conducting the research on what's effective and what's not effective.

IMPACT ON STATES

Senator ABDNOR. Do most of the States follow a lot of your recommendations?

Mrs. HANFT. We've had great success in working with the States in what we call our user liaison program where we go out at the States' request and provide information on specific subjects. We've done this in long-term care, in HMO's, and the use of nurse practitioners and physicians assistants and the use of computer technology.

Senator ABDNOR. Do you find some of those recommendations work better in some States than others?

Mrs. HANFT. Some States are more interested in making use of the material, and of course States vary in what their problems are, what their populations are like, and what their medical resources are. So it would vary from State to State.

Senator ABDNOR. That's the point I was trying to make—not with just what we're talking about here, but many of the programs we have designed. It seems like such a vast difference in the States, their makeup, their size, that it's impossible to design one to fit all States. At least your program leaves it optional for the States, if they want to accept it or not.

Have you seen a direct savings because of the programs that they have implemented through your recommendations?

Mrs. HANFT. Yes; I think what California is doing in the clinics at the moment will end up a major costsavings to the State of California.

REDUCTION IN STATISTICAL INFORMATION

Senator ABDNOR. In a time of severe budgetary restraint like we're now experiencing, what lower priority statistical information could be dispensed with and at what savings? Could you think of areas we could do away with and save substantially in the program?

Mrs. HANFT. Mr. Miller spoke earlier about the paperwork burden reduction program. That program operates out of my office, and we have been reviewing the need for data collection, both in terms of legislative requirements and regulatory requirements to meet the need—to reduce the need for data collection per se. In addition, we're currently reviewing all of the data systems in the National Center for Health Statistics to see if some of those data couldn't be collected on a more periodic basis, rather than on an annual basis—every 2 years—or instead of every 3 years, every 5 years.

Some savings probably could accrue; however, there are whole areas where we don't have data that are probably needed by State and local governments. So you have to trade off what you really think you need at what point in time versus what your resource constraints are. And sometimes the small investment you make in statistics has a big payoff in terms of how much knowledge you have to implement your program.

Senator ABDNOR. That's very true.

Mr. MILLER. Mr. Chairman, I might say that if Mr. Specter was here and was reading my biography, he'd see I've been around a long time. If I had to identify one, two, or three areas where I think the decisionmaking process is made deficient it is because of the absence of sufficient statistics. One of the last areas that I would be prone to find cuts is the development of the data base we need in order to make informed decisions.

SUBMITTED QUESTIONS

Senator ABDNOR. Thank you, Mr. Miller, and the panel. There will be additional questions that we are going to ask you to answer. I will ask that you provide the answers at the same time that you submit the corrected hearing transcript.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

HEALTH SERVICES RESEARCH: PRIORITIES

Over the past several years, many of the research activities of the National Center for Health Services Research (NCHSR) have been geared towards studying the effects of regulation on the cost of the health industry.

Question: How do you plan to redirect research activities towards determining the inflationary impact of eliminating health care regulations?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: In what areas will you be seeking new grant applications in Fiscal 1982, and how much funding will go to each area?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What existing activities are to be funded again in FY 1981?

Answer: The NCHSR studies on the effects of regulation in the health care industry are aimed at providing objective information on the behavior of the health care market and the results of various types of intervention in the market. These interventions may be in the form of additional regulation or of the relaxation of regulation and the greater influence of competition.

The following studies which have received NCHSR funds were, when approved, expected to receive funds in FY 1981.

"Competition Studies in Health Services"
Havighurst, Clark C.
Duke University

"Improving Drug Prescribing in Family Practice"
Gehlbach, Stephen H.
Duke University

"Methods to Improve Quality of Physician Prescribing"
Schaffner, William
Vanderbilt University

"Competition and Complementarity in Hospital Services"
Luft, Harold S.
University of California, San Francisco

"Impact of 'Per-Case' Versus 'Per-Service' Hospital Reimbursement"
Steinwachs, Donald M.
John Hopkins University

"A Planning Model for Primary Health Care Manpower"
Moscovice, Ira S.
University of Washington

"Model for Criterion-Referenced Medical Specialty Test"
Maatsch, Jack L.
Michigan State University

Question: Are any existing activities scheduled for termination in 1983?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: For both ongoing and scheduled new activities, please identify whether policy recommendations are to be targeted towards the consumer, the private provider, the Federal Government, or a combination of the three.

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

FINANCIAL SOUNDNESS OF HMO's

Question: How many federally assisted, qualified HMO's are currently not in compliance with the law's financial soundness requirement?

Answer: As of January 31, 1981, there are 25 HMO's classified as out of compliance with the financial soundness requirements of the law. Eleven of the 25 HMO's have implemented corrective action plans to strengthen management and financial affairs.

Question: Should the Federal Government, in your opinion, assume an increased responsibility to protect the members of "Failed Plans"?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

CONFLICT OF INTEREST IN EVALUATION GRANTS

Question: What safeguards do you have to prevent individuals and groups from getting Federal grants to evaluate the usefulness of new health care aids in which they may have a vested interest?

Answer: The National Center for Health Care Technology, in accordance with Section 309 of the Public Health Service Act, and Part 52 of the Code of Federal Regulations, uses a two-stage, non-Federal system of peer review. This system, in addition to providing staff review of conflict of interest, provides two stages of peer review to guard against overt conflict. In addition, the Public Health Grants Policy Statement declares that, "Grantees must establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties. Therefore, each institution receiving grant support must have written guides for staff members (administrators, faculty members, professional staff, or employees) and other associated individuals (such as consultants) indicating the conditions under which outside activities, relationships, or financial interests are proper or improper, and providing for notification of these kinds of activities, relationships, or financial interests to a responsible and objective institution official."

CONSOLIDATION OF HEALTH EDUCATION PROGRAMS

There are numerous programs within the Department of Health and Human Services providing health education services.

Question: How much money could be saved if existing health education programs were consolidated?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What savings would result from the States having to deal with only one Federal Bureau, instead of numerous agencies?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

STATE INVOLVEMENT IN HEALTH EDUCATION

Question: How much are the States spending now for health education programs?

Answer: In FY 1979, 29 state health agencies reporting programs in health education spent a total of $8.4 million. In FY 1980, 35 States reporting programs in health education spent a total of $8.3 million. These figures -- based on data collected for the National Public Health Program Reporting System by the Association of State and Territorial Health Officials -- must be qualified, however, since the dollar amounts only show up in the NPHPRS figures where the state considers health education to be a separate program. Other funds may go to health education activities -- under a hypertension or alcohol abuse control program, for instance -- and not appear in the NPHPRS data.

There are no data available to show what the states are spending for school health education, from either the Department of Health and Human Services, the Department of Education, or the private sector Association for the Advancement of Health Education.

Question: If the States are given more discretion for deciding the exact array of health education programs, what emphasis do you expect would be placed on programs such as hypertension and family planning?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HEALTH SERVICES RESEARCH

Question: To what extent has research sponsored by the National Center for Health Services Research during the last three years led to changes in health care policies that saved Federal health outlays?

Describe any such research projects and estimate the amount of savings involved.

Answer: The mission of the National Center for Health Services Research (NCHSR) under its legislative authority is to undertake and support research, demonstrations, and evaluations on problems in the organization, delivery, and financing of health care services; serve as the focal point for coordination of health services research within the Public Health Service; and disseminate the findings of health services research to policy and decisionmakers in the public and private sectors.

In carrying out this mission, NCHSR summarizes the results of the studies which it has supported, as well as findings from other sources, and conveys this information to policymakers and program administrators. There is an extensive dissemination program to provide the results to users at Federal, State and local levels.

Since NCHSR is a research organization, it is not directly involved in formulating, choosing or recommending specific policies. Its task is to provide information and the results of experience to those who determine policy. The information provided by NCHSR is generally one source of knowledge used by policymakers to assist them in their choices among policy options. The results of research often reveal the opportunity to follow a course of action which could yield outlay savings, but other factors must also be taken into account by those making the decisions.

A review of the experience of NCHSR on several issues on which it has sponsored research provides some evidence of financial implications of its findings.

o NCHSR played a key role in the development of publications which review the research on issues related to health care cost containment:

  -- Hospital Cost Containment, Selected Notes for Future Policy, Edited by Michael Zubkoff, Ira E. Raskin, and Ruth S. Hanft, 1978.

-- Controlling Health Care Costs: An Evaluation of Strategies. Ira E. Raskin, Rosanna M. Coffey, and Pamela J. Farley, 1980.

Research supported by NCHSR has examined significant aspects of cost containment issues. The following are examples:

-- Effects of the payment mechanism on the health care delivery system.

-- Changes in the costs of treatment of selected illnesses.

-- A study of the utilization experience of the Federal Employee Health Benefits program.

-- Impact of the economic stabilization program on hospitals.

-- The productivity of health manpower.

-- Financing of catastrophically expensive illness.

-- Determinants of physicians' fees, and physician fee inflation.

o An important intramural study under way is examining hospital costs and utilization. This study is securing data on a sample of hospitals in the U.S. to explain variations in levels and patterns of hospital utilization -- both of which are important determinants of hospital costs.

The research explores the implications of variations in hospital use for costs as well as for access and the quality of care. The findings are expected to provide new information for developing strategies directed toward altering utilization levels and patterns, and for predicting hospital behavior in response to specific cost containment policies. The studies focus on how and why hospitals differ in such characteristics as case mix, lengths of stay and ancillary services used for specific illnesses, occupancy rates, capitalization, and manpower utilization.

o Results of a study supported by the NCHSR and carried out at Duke University Medical Center show that the heart attack victims who experience no complications during the first four days of illness can be considered for discharge on the seventh day of hospitalization -- eight to ten days less than the average length of stay for the illness. This finding has the potential of reducing expenditures for hospital care by more than $360 million annually.

c The NCHSR has pioneered in the development of clinical data banks. These data banks provide a new approach to assessing clinical decisions for individual patients and for evaluating the value of specific diagnostic and therapeutic technologies. The value of these data banks is now widely acknowledged. For example, the ARAMIS data bank at Stanford University has been used to assess the value of renal biopsy. As a result of this analysis, it is now evident that this procedure provides no information beyond that already available from standard kidney function tests in patients with a particular connective tissue disease. This finding has not only eliminated the risks associated with this procedure, but has also reduced the costs of care -- approximately $500 for every patient.

o Screening for cervical cancer by testing at four year intervals instead of annually could result in significant cost savings nationwide and only a slight increase in the numbers of deaths due to the disease. That is the suggestion of a study on the costs and benefits of the Pap Smear test by Stuart Schweitzer and Bryan Luce of the University of Southern California, with support from the National Center for Health Services Research. Results indicate that annual Pap Smear screening for cervical cancer costs about $76,000 per incidence detected, compared to about $18,000 when screening is done at four year intervals.

o A study of the effects of the use of the certificate-of-need procedure to limit capital expenditures by hospitals was conducted in Massachusetts under a grant from NCHSR awarded in 1977. The study examined the amount and kinds of capital investment made in Massachusetts' voluntary hospital industry from 1967 to 1976, a period which spanned five years before and five years after introduction of certificate-of-need (CON) regulations in that State.

Over the period 1972 to 1976, 25 percent of all projects submitted by sample hospitals to CON were either denied or modified significantly through review. By 1976 and beyond, as the regulatory process matured, CON review reduced project scale and cost by as much as two-thirds of that originally proposed.

HEALTH SERVICES RESEARCH: CONTROLLING COSTS

Question: Which savings were attributable to changes in agency policy and which were consequences of Congressional legislation?

Answer: The information which results from health services research is one of the factors which enter into the decisions by Congress and by operating agencies which can affect costs and savings. It is seldom possible to identify direct cause and effect.

Many witnesses before Congressional Committees provide testimony which is based in part on findings which they have produced in research supported by the National Center for Health Services Research (NCHSR), or which they have found in the literature reported as a result of NCHSR funded research.

Question: Please cite examples of savings that have not been realized because of failure to implement the Center's recommendations or due to only partial implementation of recommendations.

Answer: The direct link between National Center for Health Services Research (NCHSR) research and the failure to produce savings is also difficult to identify as observed above. Examples of NCHSR findings on this point follow:

- NCHSR sponsored a major analysis of the implementation by the Federal Government and the States of two important legislative enactments to improve child health - the Maternal and Child Health program under Title V, and the Early and Periodic Screening, Diagnosis and Treatment program under Title XIX of the Social Security Act. An intensive study in two sample States was conducted.

  The findings on gaps, failures, and fragmentation of policy, although not generalizable, could have major implications for the successful implementation of other public health policies. George A. Silver, M.D., principal investigator, found that the legislative intent and the objectives of the Federal regulations were ambiguous. Thus, the potential for conflict and uncertainty on goals was built in at the outset. The States, faced with uncertain policy, limited funds, and external pressures, fell short of complying with their mandate. The findings suggest that Congress and concerned Federal agencies should give greater attention to the implementation process in developing public policy strategies, and that new legislation be more specific as to the target population, types of services expected, the costs, and administrative framework.

- A recent study supported by the NCHSR was cited as the basis for legislative action in the Michigan legislature to examine the effectiveness of the State Generic Drug Substitution Act of 1974. The study revealed that in a one-year period only 2.8% of a possible 15 million prescriptions were filled with an allowed generic substitute.

HEALTH STATISTICS: DETERMINING WHAT INFORMATION IS NEEDED

The National Center for Health Statistics is designed to collect and provide needed information to government, the health industry, and consumers of health services.

Question: What part does each group play in determining the priorities in terms of what information is needed?

Answer: The National Center for Health Statistics establishes priorities for the collection of statistical data and health information through an extensive consultative process with user groups.

Government agencies are heavily involved with the Center in planning the content of surveys, developing supplemental questions to be used in conjunction with on-going Center surveys and utilizing the data collected. The Health Care Financing Administration and the National Center for Health Statistics, e.g., are con-jointly financing the current National Medical Care Utilization and Expenditures Survey.

The health industry is one of the largest consumers of NCHS data and is continuously consulted on data projects that impact on this industry. Data tapes are acquired by the Center from the American Medical Association, American Nursing Association and the American Hospital Association.

Consumers of health data serve as a resource to the Center in terms of maintaining touch with consumer needs. The Center responds to over 100,000 requests for data each year from consumers in both the public and private sector. In addition, the National Committee on Vital and Health Statistics, which is composed of members from the private sector, advises the NCHS on its data activities and on future directions for its programs.

Question: When working in conjunction with the Bureau of the Census, does the Center assist in developing questions on health issues, or does the Bureau of the Census determine what information will be collected?

Answer: The Center, after consultation with a wide array of health care providers and consumers, and with local, State and national organizations and governments, specifies the specific health information that is to be collected. The Bureau of the Census provides a data collection and processing service thus not requiring the Center to duplicate those field staff resources currently available to the Census.

The second area in which the Center is involved with the Bureau of the Census is the decennial Census. In this case the Center is one of many organizations which have input into the health and health-related questions which are included in the Census.

TRAVEL, TELECOMMUNICATIONS, AND STAFF UTILIZATION

Question: How much have you requested for travel expenses in fiscal year 1982?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: To what extent has greater uses of telecommunications and videos in lieu of travel been explored for the agencies under your jurisdiction?

Answer: Realizing the need to reduce travel, PHS has explored various uses of telecommunications and video equipment to save energy and reduce costs. As an example, the National Institutes of Health has installed domestic and foreign conference lines, to transmit information by telephone. In addition, they are using high speed facsimile equipment and an electronic blackboard which allows offocials and scientists at two locations to participate in bi-weekly laboratory directors' meetings and scientific, educational and training seminars without resorting to travel.

A three month analysis showed promising results. Conferences were successfully held via the telephone and facsimile transmissions were beneficial in managing a large field activity. In many instances travel between two locations was eliminated, which resulted in monetary travel savings as well as employee time savings.

Question: What are your anticipated expenses in 1982 for publication and distribution of various materials?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: What are the Office of Program Direction and Support Services initiatives for Fiscal Year 1982?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: How does OASH intend to implement better staff utilization?

Answer: Efforts to implement better staff utilization have resulted in the development of the Manpower Management Program (MMP). A program goal has been to quantify OASH work and to associate with it staff resource utilization for the purpose of using it in budget formulation and budget execution activities. MMP data was utilized to determine OASH position levels in the FY 1982 budget. Some OASH offices have integrated their MMP data with existing operational work planning, including the Performance Appraisal System.

Through continued efforts such as these, better staff utilization can be implemented in OASH. We are confident better staff utilization will occur as a result.

BLOCK GRANT

Question: Which of your programs are proposed for inclusion in block grants to States?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: Specifically, are health education and adolescent health programs proposed for elimination, to be folded into a block grants program?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HEALTH EDUCATION

Question: What percentage of your efforts are directed toward health education and what percentage goes for health information dissemination?

Answer: For the Office of Disease Prevention and Health Promotion in the OASH approximately 13% of program efforts go toward health education activities. Most of these efforts are in the form of technical assistance and cooperative arrangements with other Federal agencies and some private sector organizations. On the other hand, approximately 34% of program efforts go toward health information dissemination activities. Most of these efforts are associated with the Office's response to public inquiries, operation of the National Health Information Clearinghouse, and conducting and participating in conferences, seminars and other meetings. In addition to these efforts, we are currently conducting a National Health Promotion Media Campaign which is a multimedia campaign to introduce the concept of relative risk and personal control over health status through choices that contribute to a healthier life-style. It is an activity through which is woven health education and health information dissemination efforts and thus is an example of how difficult it is to differentiate between these two activities. Approximately 9% of staff program efforts are devoted to conducting the campaign.

NATIONAL HEALTH SERVICES RESEARCH

Question: Why are you planning to abolish the "User Liaison" program, rather than phasing down its present level of funding?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Question: Are the Medicare claims processed by the HMO's or the members?

Answer: Under Medicare/HMO contracts, since all care is provided on a prepaid basis, no individual claim forms are necessary. In addition, HMO contracts cover both the beneficiaries' deductible and co-insurance, so no forms must be processed either by the patient or the HMO. This leads to significant economies for the government and the HMO. The sometimes burdensome submission of claim forms by the beneficiary is no longer necessary, and enrollment in an HMO eliminiates out-of-pocket expenses for the individual, other than the monthly premium payments.

HMO contracts cover all basic Medicare services, plus the co-insurance and deductible. If an individual chooses to seek care outside the HMO, the individual must follow the normal procedures for obtaining reimbursement from Medicare, including submission of claim forms. However, all HMO's provide full service packages, so such out-of-plan usage is not necessary.

Question: If the Medicare forms are handled by the HMO's, are there consequent reductions in form error? Are reimbursements for Medicare services made more quickly?

Answer: As noted in the response to the previous question, with HMO/Medicare coverage there are no claim forms necessary since all care is paid for in advance through the monthly premiums. Since HMO's receive payments in advance, reimbursement to the HMO is more timely than that to private practitioners or patients.

DISPARITIES IN FEDERAL AND STATE REQUIREMENTS FOR HMO's

Many States have qualification and licensure requirements that differ from the Federal qualification and licensure requirements relevant to Health Maintenance Organizations.

Question: What conflicts and confusion exist between State and Federal qualification and licensure requirements?

Answer: Regarding licensure, State laws vary and HMO's must meet both State and Federal requirements if there is a variance. During the past three years Federal and State regulators have been meeting and making progress in achieving consistency and avoiding conflict in State and Federal regulatory requirements. In 1976, Section 1311(c) was added to the Federal HMO Act which directed the Secretary to report to the Governor of each State any provisions of State and Federal laws impacting on HMO's which are inconsistent. This section specified that an examination be performed which explores state laws, regulations, and other provisions which (1) require medical society approval of the furnishing of services by the HMO; (2) require that physicians constitute all or a percentage of the governing body; (3) require that all or a percentage of physicians in the locality participate or be permitted to participate in the HMO; and (4) require that the entity meet the requirements for insurers of health care services respecting initial capitalization and the establishment of financial reserves. If State laws prevent an entity that is federally assisted under Title XIII of the Act or qualified under section 1310 of the Act from doing business as an HMO, these state laws, regulations and other provisions would be reported so as to prevent the HMO from operating in that state in accordance with requirements of the HMO Act. Section 1311 also flatly prohibits a fifth category of State laws: those which prevent a federally aided or qualified HMO from soliciting members through the advertising of services, charges or other nonprofessional aspects of its operation.

The number of State laws which contain provisions defined or restrictive is steadily decreasing. There are still some restrictive provisions remaining in some State laws, but most of these are found in those states that have failed to adopt explicit HMO legislation. (These states are Alabama, Alaska, Delaware, Hawaii, Louisiana, Mississippi, Missouri, Montana, New Mexico, Oregon, Wisconsin, Wyoming, and District of Columbia.)

STATISTICAL DATA ON STATE REGULATION OR ORGANIZATION

States with HMO Laws	39
States with Service Corps. Laws without Basic Section 1311 Restrictions	0
States Without Prepayment Regulations per se	1
States with Statutory Provisions in Areas Addressed by Section 1311	39
Category 1: Medical Society Approval	1
Category 2: Governing Body Percentage	3
Category 3: Physician Participation Percentage	1
Category 4: Insurers' Reserve or Capital	21
Category 5: Advertising Restrictions	23
States with More than one Statutory Provision in Areas Addressed by Section 1311	14

Question: Should the current system of Federal Qualifications be continued?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What is the Department doing to eliminate disparities between Federal and State HMO requirements?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: Could the HMO movement be strengthened indirectly by lifting some of the Federal planning and eligibility restrictions that now inhibit its growth?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

There has been a recent trend towards the establishment of Health Maintenance Organizations (HMO's) that will supplement Medicare benefits.

Question: How many privately financed HMO's in existence or in the planning stages cooperate with the Federal Government in supplementing Medicare Benefits?

Answer: The Office of HMO's is involved only with the 118 federally qualified HMO's, of which 51 currently contract with HCFA. There are approximately an additional 120 HMO's and prepaid health plans that may provide supplemental coverage to Medicare beneficiaries, but PHS/OHMO has only limited information on these organizations.

Our HMO reporting requirements are limited to the requirements of Title XIII. Since provision of supplemental benefits under Medicare is (an optional service which is) not covered under Title XIII, the Office of Health Maintenance Organizations does not monitor such coverage nor maintain specific information in this area.

Question: Do the monthly charges compare favorably with other supplemental insurance costs?

Answer: Since Title XIII does not cover this area, the Office of Health Maintenance Organizations does not request or maintain information on supplemental benefit packages; as a result, we are not able to respond to this question (see previous question).

It should be noted, however, that most supplemental packages offered by standard insurers (for example Blue Cross/Blue Shield) are intended to cover the co-insurance and deductibles under Medicare; HMO's that contract with the Federal government automatically provide this supplemental coverage in their standard premiums. Therefore, any additional coverage provided by the HMO relates to services not normally reimbursed for by Medicare. It is difficult, therefore, to compare HMO supplemental packages and premiums with those offered by other insurers, since the services covered are different.

Question: How readily can HMO's be adapted to supplement the Medicare needs of the elderly in rural areas?

Answer: To provide supplemental benefits for Medicare beneficiaries, rural HMO's must first contract with Medicare to provide basic services for the elderly, and then elect to develop and market a supplemental benefit package. As mentioned previously, 51 federally qualified HMO's currently contract with Medicare to provide basic benefits.

Question: Can rural satellites of urban-based HMO's successfully be established to supplement Medicare benefits?

(Background: The St. Paul Pioneer Press (Minn.), 1/16/81, announced that the Metropolitan Senior Federation and Physicians Health Plan have established an 11 county HMO that will supplement Medicare benefits. The monthly charge will be $24 a person, covering virtually all costs not covered by Medicare, except prescriptions.)

Answer: HMO's that establish financially viable rural satellites to serve the general population can opt to contract to cover Medicare beneficiaries, and also implement a supplemental benefit package. In areas with low population density, a satellite that covers only the elderly would probably not be fiscally viable.

HEALTH STATISTICS COLLECTION

The National Center for Health Statistics (NCHS) provides for the collection, analysis, and publication of national health statistics through the operation of a number of national systems.

Question: During the recent past, what percentage of the surveys have been conducted directly? Through the Bureau of the Census? Through private contractors?

Answer: The Surveys conducted by the Center are usually not performed exclusively by one source. We have found it best to use the resources and knowledge most appropriate to the task. Therefore, more often that not, portions of each survey will be done by Census or contractor coupled with direct participation of the Center staff. Of the eight major surveys being conducted by the Center, 38% are conducted directly by Center personnel, 12% by the Bureau of the Census, and 50% by private contractors.

Question: How does the Center insure comparability and reliability of the various health statistics it gathers or uses from other agencies?

Answer: The Center specifies the requirements of the data, and compiles, regardless of whether it collects the data itself or arranges to have the Census Bureau or private contractors serve as its data collector. When the data are collected by contractors, the data requirements are included in the contract specifications, and the Center staff closely monitors the contractor and the data collection operations to assure that the data requirements are satisfied. In this manner, the Center assures data comparability and data quality for the health statistics that are gathered by other agencies for the Center's use. If another agency collects health data but not exclusively for the Center's use, the Census usually does not have the authority to assure data comparability and data quality. In these instances, the Center tries informally to reach understandings with the other agencies by agreeing on minimal data sets and by standardizing the forms and definitions. If despite these precautions, the data compiled by other agencies do not meet the Center's standards for data comparability and reliability the Center will either appropriately qualify these statistics in its reports or reject the statistics as being unsuitable for publication in its reports.

COST OF STATISTICAL PUBLICATIONS

Question: How much do you spend on publication and distribution of statistical information?

Answer: The budgeted amounts to be spent on publication and distribution of statistical information by NCHS is $1,535,000 in FY 1981 and an estimated $1,595,000 in FY 1982.

Question: How much of this expenditure is recovered through sales and subscriptions?

Answer: NCHS does not directly sell publications. Data tapes are sold, however, and it is estimated that $36,000 will be recovered by the Center in FY 1981 and $37,000 in FY 1982 from these sales.

Both NCHS statistical publications and data tapes are also sold through the National Technical Information Service and the Government Printing Office although these funds are not recovered by NCHS. These sales amount to an estimated $50,000 annually.

COOPERATIVE HEALTH STATISTICS SYSTEM

The Cooperative Health Statistics System (CHSS) was established for the purpose of producing comparable and uniformed health information and to assure appropriate access to such data. Last year, the Center proposed a reduction in funding for the Cooperative Health Statistics, and placed greater emphasis on state agency capability and coordination.

Question: How has State Agency capability responded in the last year?

Answer: The response to emphasis on State Agency capability has been remarkable. The Governors and legislatures of 34 States have designated State CHSS Agencies to coordinate health statistics in individual States and adhere to guidelines for further State Agency development. Many States have made considerable progress in areas other than direct data collection--particularly in data analysis and dissemination, and in planning a coordinated system. Thirteen States, under developmental contracts, are improving capabilities over the range of State Agency functions. Response on the part of the States to our contract solicitation, and the 34 States that have designated a State CHSS Agency, indicate the commitment and interest on the part of States in this program.

Question: Has the funding reduction caused any specific problems for the State Agencies?

Answer: During the past year many States have been in a difficult transition from Federally funded data collection (manpower and facilities) systems to partial State funding. As a result the overall capabilities, in terms of direct data collection and trained staff retained, has diminished in many States.

These funding reductions are further limiting the States efforts to coordinate and improve statistical activities at the State level, and remove much of the incentive for States to designate focal agencies for the coordination of statistical activities.

Question: How many of the State agencies now receive contract support for the various components of the system?

Answer: In FY 1980, 44 State Agencies received contract funds for CHSS vital statistics; 30 for health manpower; 36 for health facilities; and 13 State Agencies received funds for State Agency Development projects. Thirty-six States had previously been funded in health manpower, but due to budget reductions in FY 1980 six States were not funded in that componenet. The further budget reduction in 1981 has resulted in total elimination of CHSS Health Manpower and Health Facilities and continuance of only the vital statistics component in the 44 State Agencies.

COORDINATION OF VARIOUS STATISTICAL AGENCIES

Question: How do you insure comparability and reliability of the various health statistics you gather or use from other agencies?

Answer: The Center specifies the requirements of the data and compiles it, regardless of whether it collects the data itself. When data are collected by contractors, requirements are included in the contract specifications and the Center staff monitors the collection operations to assure that the data requirements are statisfied. In this manner, the Center assures data comparability and data quality for the health statistics that are gathered by other agencies for the Center's use. If another agency collects health data, the Center usually does not have the authority to assure data comparability and data quality. In these instances, the Center tries informally to reach understandings with other agencies by agreeing on minimum data sets and by standardizing the forms and definitions. If the data compiled by other agencies do not meet the Center's standards, the Center will either qualify these statistics in its reports or reject the statistics as being unsuitable for publication. In addition, the PHS and the Department have two coordinating committees and statistical review processes which review proposed data instruments prior to their implementation.

Question: What efforts have you made to determine if savings are possible by combining your work with the statistical gathering efforts of such agencies as the Bureau of Labor Statistics, the Bureau of the Census, the Occupational Safety and Health Administrations, and the Health Care Financing Administration?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

UTILIZATION OF HEALTH SERVICES RESEARCH

Question: It is the responsibility of the National Center of Health Services Research (NCHSR) to disseminate its findings in the public and private sectors. Wheich methods for dissemination of the Center's findings have been the most successful, and which others the least successful?

Answer: Dissemination is a major focus of NCHSR activities. To disseminate the many findings from health services research to this diverse community, NCHSR employs a number of different dissemination strategies, including publications, meetings, and presentations.

Publication strategies include several series produced for selected audiences. For example, the Research Summary Series provides specific research findings in a concise form to those policymakers, health administrators, and health planners who need to know about relevant research findings promptly. The Policy Research Series describes those research results which are particularly important in current policy discussions; it is directed to those in the private and public sectors who are responsible for considering, designing and establishing policies affecting the delivery of health care. The Research Management Series presents information about research goals, priorities, and opportunities to investigators, research planners, and administrators. The Research Proceedings Series contains the research findings and discussions presented at NCHSR conferences and seminars to those health services investigators and providers who benefit from examining the concepts and ideas which appear during the exchange of research results. The Research Report Series disseminates complete reports of particularly significant studies to scientists and others who analyze technical reports in detail. Other examples of publications intended for selected audiences are the series of special reports presenting results from the National Health Care Expenditures Study and from the Hospital Cost and Utilization Project.

Several kinds of NCHSR publications are intended for more general audiences. Research Announcements are capsule summaries of research findings prepared as soon as the results are received and reviewed for accuracy -- these Announcements often form the basis for articles appearing in the popular press. The Research Digest Series provides overviews of both on-going and completed projects which address issues of high priority to significant groups of users; these reports, written in non-technical language, are intended for large audiences.

The preparation of research syntheses is also an important dissemination effort. These reports collect and evaluate the status of research on a particular subject, such as long-term care or medical information systems, and are used by researchers, planners, and policymakers. Publications in technical journals, and presentations and exhibits at numerous scientific and public meetings, are also major dissemination activities. In selected research areas it has been possible to adopt the dissemination model used so successfully in biomedical research, developing specialized communications networks with discrete groups interested in such categorical topics as emergency medical services systems or computerized medical record systems.

Approximately 3 years ago, NCHSR concluded that the growing importance of the role of State and local health leaders in the delivery of care throughout the nation warranted development of a series of special efforts by NCHSR to communicate research findings to them. A variety of activities has been undertaken involving face-to-face meetings with State and local health leaders. For example, several 5-½ day workshops have served to introduce senior State and local health officials to health services research in a manner that will enhance their ability to interpret and use research findings. Other workshops have been arranged to address various significant issues in a more substantive fashion. These face-to-face contacts have been particularly effective -- not only because they have been notably successful in transmitting knowledge but also because they enable NCHSR to comprehend better the research needs of such leaders and thus adjust our research program accordingly.

Question: Which have been the most cost-effective?

Answer: Each strategy focusses on a particular set of user needs and no single strategy can be equally effective for all users. The NCHSR experience suggests that face-to-face contacts between the users of research and NCHSR results in numerous specific direct requests for materials. In this sense, the dissemination activities are cumulative, stimulated first by general publications and presentations. The real impacts may come later from follow-up to specific requests. To be effective, a dissemination program must include both.

Question: How does the Center intend to expedite response to its recommendations in the future?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What assurance do you have that the Department will implement your recommendations?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What are your expenditures for printing, reproduction, and mailing of the Center's publications?

Answer: The National Center for Health Services Research (NCHSR) spends about $250,000 annually in printing and duplicating its publications series as well as informational items. Mailing costs average about 30¢ per publication and 8½¢ per issue of Research Activities. It is estimated that approximately $60,000 will be expended in 1981 for mailing the Center's publications.

Question: How much of that expenditure is recovered through sales and subscription?

Answer: NCHSR does not directly sell its publications to the public. Initial distribution is made without charge to research users by means of mailing keys which target specific audiences, and which are continually updated. Secondary distribution is made by the

U.S. Department of Commerce, National Technical Information Service, which announces all NCHSR published reports, as well as all grantee and contractor final reports, through its bi-weekly Government Research Reports, and offers these documents for sale to the public. In addition, magnetic tapes containing computerized data from research projects are offered for sale through NTIS, and more than 20 major data sets are now available in this manner. Rates charged by NTIS are sufficient only to cover NTIS expenses, and NCHSR derives no revenue from the sales, which amount to an estimated $50,000 a year. Similarly, the Superintendent of Documents, U.S. Government Printing Office, offers NCHSR publications of general interest for sale to the public, and makes a free distribution to each of the Federal Depository Libraries nationwide.

USE OF TELECOMMUNICATIONS IN DISSEMINATION EFFORTS

Question: How has the National Center utilized telecommunications in lieu of travel for gathering and dissemination of research findings?

Answer: In both gathering and disseminating research findings, NCHSR relies heavily on communication by mail. Travel is not frequently involved. The NCHSR Publications and Information Branch uses telecommunications to a great extent in preparing informational items. In addition, many of the informational requests, particularly those from the press, are handled by telephone.

DISSEMINATION OF HEALTH CARE TECHNOLOGY

Question: How is health care technology information disseminated to the practitioner?

Answer: A major objective of the National Center for Health Care Technology (NCHCT or Center) is to insure that the evaluative information which it generates about health care technologies is disseminated widely and expeditiously, and in a useful form. The Center uses a variety of mechanisms to disseminate such information, e.g., reports to the professional and general press and media outlets; direct publication and distribution of materials developed by the Center; publication through Federal informational services, such as those of the National Library of Medicine and other components of the National Library of Medicine and other components of the National Institutes of of Health (NIH), and of the Food and Drug Administration (FDA); medical, scientific, and other professional organizations; and, meetings and conferences held by the Center and various professional, governmental, and other groups.

After technology assessments and Center-sponsored conferences are completed, the NCHCT disseminates information in two stages. Within one month after a conference or a significant phase of the assessment is completed, a summary highlighting the major findings and recommendations is published. The second stage involves the release of a full technical report on the subject technology or edited proceedings of the conference, or both. The NCHCT also publishes monographs and "Fact Sheets" on particular technologies for use by practitioners and other interested parties. These publications provide background or "state-of-the-art" information on the subject technology, identifying the key issues related to its development and potential or actual use.

To provide an additional service useful to the practicing community and others involved in the health field, and the public, the NCHCT also plans to publish the medical and scientific information that is generated through its evaluation of Medicare coverage issues. The Memorandum of Understanding that was negotiated recently between the Public Health Service (PHS) and the Health Care Financing Administration (HCFA), delineating, formalizing, and strengthening the relationship between the two agencies in the Medicare coverage determinations process, enables the NCHCT to publish, for the first time, the results of these evaluations. Consistent with its policy of openness, the basis for any particular Medicare coverage recommendations also will be made public by the Center. A variety of mechanisms will be employed to disseminate, in a useful form, to health care providers and others the results of the Center's evaluations of Medicare coverage issues; e.g., direct publication of "Fact Sheets" and special monographs, as appropriate, on the individual technologies involved; summary reports in the Center's newsletter; and, the publication of articles in medical, scientific, and other appropriate journals.

As assessments of specific technologies are completed the National Council on Health Care Technology (Council) may develop and disseminate guidance regarding the appropriate use of these technologies. This information is intended to assist practitioners and others who are responsible for making decisions about health care technologies in the delivery of health services, so as to help ensure the provision of the highest quality care at the lowest possible cost.

Question: To what extent are telecommunications and videos used, in place of travelling, for dissemination, demonstrations, and technology training?

Answer: To date, telecommunications and videos have not been developed because the NCHCT's limited information dissemination resources have been used to meet the need, as demonstrated through requests, for published materials. However, several mechanisms for disseminating information, involving the use of audio-visual media, are planned for the next fiscal year. For example, plans have been initiated for the development of a video presentation on technology assessment that can be mailed to the media and other interested groups. Also, a travelling exhibit program and a speakers bureau will be developed to provide various target groups with information about Federal priorities, programs, and capabilities for technology assessment. The NCHCT will continue to identify and employ innovative, effective, and cost-effective approaches to information dissemination.

HEALTH STATISTICS: MONITORING AND TIMELINESS OF DATA

Two program support activities of the National Center for Health Statistics are to develop better methods of performance reporting and monitoring and to improve comparability and timeliness of data.

Question: What improvements of these two activities have been developed in the last year, and at what costs or savings to the Department?

Answer: The National Center for Health Statistics has instituted a Program Performance and Management System to maintain continuous surveillance over priority Center activities. The institution of this system will insure adherence of program activities to program plans and improve timeliness of data. The NCHS also instituted the Performance Appraisal System (PAS) for all managers.

Question: To what extent have telecommunications been utilized as an alternative to travel of program support personnel?

Answer: The Center has effected a 69% reduction in travel costs in 1981, which was made possible, in part, by a concerted effort to acquire and use communicating word processing and computer terminals along with greater use of FTS telephone service. While telecommunications costs have increased 10%, the net savings to the government has been approximately $100,000.

HEALTH EDUCATION

The Public Health Service has been interested in school health and now the Department of Education is interested in school health.

Question: Tell us, how much money does the Public Health Service spend on health education programs in the schools?

Answer: In FY 1980, the Health Education/Risk Reduction project grant program, administered by the Center for Health Promotion and Education, Centers for Disease Control, spent $5.3 million on smoking and alcohol abuse education projects in the schools.

For the Alcohol, Drug Abuse, and Mental Health Administration a total of $3,470,000 was spent in FY 1980 for projects in the schools. This amount was for drug abuse and alcohol projects.

Question: Can you submit a listing of all programs supported by the Public Health Service which are earmarked for curriculum instruction for school-aged children and youth?

Answer: The Center for Health Promotion and Education, Center for Disease Control (CDC) earmarked the following amounts for direct support to school districts for curriculum development: $40,000 in FY 1979; $40,000 in FY 1980; and $20,000 in FY 1981.

The Center for Prevention Services, CDC, funded a $30,000 project in FY 1981 to develop a curriculum guide on sexually transmitted diseases.

For the Alcohol, Drug Abuse, and Mental Health Administration a total of $2,209,000 was spent in FY 1980 for projects related to curriculum development in the schools.

Question: How much money does the Public Health Service spend for health instruction programs which are earmarked for upgrading the skills of teachers who have the responsibility to teach health?

Answer: The Center for Health Promotion Education, Centers for Disease Control, earmarked the following amounts for teacher training institutions to upgrade the teaching skills of school health educators: $100,000 in FY 1979; $100,000 in FY 1980; and $150,000 in FY 1981.

Question: How have you and the Department of Education avoided duplication of efforts in school health programs? Have you developed any interagency agreements or made any other arrangements with the Department of Education in school health?

Answer: Duplication of Department of Health and Human Services' efforts in school health and those of the Department of Education have been avoided as a result of the following action:

1) All Department of Health and Human Services' programs and activities in school health are discussed, prior to initiation, with the Director of the Office of Comprehensive School Health (Department of Education). This avoids duplication of effort and allows for changes to be made in Department of Health and Human Services' programs to assist the Department of Education accomplish its goals.

2) The Director of the Office of Comprehensive School Health is a member of the Advisory Committees for all school health evaluation and curriculum projects sponsored by the Department of Health and Human Services.

3) All meetings and conferences on school health convened by the Department of Education or the Department of Health and Human Services include representatives from both Departments at the planning and implementation phases.

4) All grants application received by the Department of Health and Human Services involving school health are sent to the Office of Comprehensive School Health for review and comment.

SMOKING AND HEALTH EDUCATION

Question: What percentage of your efforts are devoted to health education as it pertains to smoking?

Answer: Approximately 25 percent of the $3,000,000 budgeted for the Office on Smoking and Health -- $750,000 -- is devoted to health education and information. This work includes efforts through television, radio and the print media to reach young people, to encourage them not to begin smoking, and to reach adults to help them quit if they wish to do so, or to show then how to smoke with less hazard if they wish to continue smoking. This $750,000 compares with more than $1 billion spent by the cigarette manufactures in advertising and promotion.

Question: How do your efforts differ from other health education programs that deal with smoking?

Answer: Broad efforts in health education are being carried on by many agencies to reach young people and adults, in local, State, and Federal government agencies and voluntary agencies. In many cases, particularly in schools and with children and young people, information about the hazards of smoking can and should be combined with information about other health concerns, such as diet, alcohol, etc. In other cases, as when addressing older young people, or developing messages for the media, the smoking effort should and must stand alone. The program of the Office on Smoking and Health differs from other health education programs in focusing on the smoking problem alone. It supports but does not directly sponsor overall health education efforts.

Question: Is there any reason for not consolidating smoking and health education programs into the jurisdiction of just one agency?

Answer: Whether a program of this kind should be administered as a separate entity or by an organization which also administers other health education programs, however, is a management question. Historically, the Department has housed its smoking and health programs both in separate agencies and in a special office in the Office of the Surgeon General. Some efficiencies may be gained, however, by combining Smoking and Health organizationally with other Health Education activities.

HEALTH STATISTICS: DETERMINING WHAT INFORMATION IN NEEDED

Question: What is the turn-around time on health data collected through your program; for example, from the time information is collected, how long does it take before that data is available for public consumption?

Answer: The National Center for Health Statistics regularly operates some fifteen or so data systems. The turn-around time varies, of course, by the type of data under consideration.

Vital statistics are collected on a continuous basis. Vital events, such as births and deaths, are registered locally, under the civil laws of the respective States, at the time they occur. Each State then, at intervals, transmits either microfilm copies of the vital certificate or machine readable tapes to the National Center for Health Statistics. In order to ensure the timely detection of any new trends, two reporting systems are maintained: a system to produce provisional estimates and a system to produce definitive, detailed statistics.

Provisional estimates are published monthly. Each month's report covers the period ending approximatley ten weeks prior to the publication date. Estimates are available concerning births, deaths, infant deaths, marriages, and divorces. For the United States as a whole, deaths are classified into 72 groups according to cause of death. Certain broad estimates are made on a State-by-State basis. The monthly provisional estimates have proven to be generally quite accurate, but they cannot provide the diagnostic and geographic detail needed for some purposes. Aggregating provisional data for entire years permits somewhat more detialed estimates. Annual provisional figures are published between five and ten months after the end of the year. The 1979 annual provisional estimates were published November 1980. The 1980 provisional estimates are expected to be issued during August 1981.

The time interval between the close of the data year and the availability of detailed, final vital statistics has varied from year to year. That interval depends on the speed with which the States submit their forms or data tapes and on competing demands on the National Center for Health Statistics staff. The final 1978 natality data became available in April 1980, 16 months after the end of the data year. The final 1978 mortality data became available in September of 1980, some 20 months after the end of the data year. These intervals are somewhat longer than we had been experiencing in the recent past and we anticipate even somewhat longer intervals in the immediate future. Budgetary constraints in some of the States have resulted in delays in transmittal to the National Center for Health Statistics of data tapes meeting the requisite quality-control standards. In addition, it has been necessary to make time-consuming modifications in computer software to conform to the worldwide shift from the Eighth to the Ninth Revision of the International Classification of Diseases. (Revision of the Classification was needed to accommodate to recent advances in medical knowledge.) The immediate impact of this shift, which officially took place on January 1, 1979, will soon have run its course. Somewhat shorter time intervals can be anticipated during the remainder of the decade until the next revision comes into effect.

The turn-around time for vital statistics data has been covered in some detail here to convey the complexity of the problem. Rather than cover in similar detail each of the approximately fifteen other data systems, some general observations are here provided. Should the Committee desire a detailed account for each of the data systems, we should of course be pleased to provide one.

1. A great deal of statistical information pertaining to a given time period is readily available to a potential user prior to the formal publication of the data. For instance, although one volume of official 1977 mortality statistics is not as yet in print, the statistical information that is to appear in the volume has been available, upon request, since May 1979. The pre-publication availability of tabular materials is widely known and the National Center for Health Statistics regularly services a large number of requests for prepublication tables derived from each of its data systems.

2. Because of the relatively long turn-around time between data collection and the availability of the final printed reports, a number of mechanisms for the early dissemination of summary data are employed. The publication of provisional vital statistics was discussed above. The Center also issues a series entitled "Advance Data from Vital and Health Statistics." The reports in this series are relatively short summaries which provide the public with preliminary information. Results from a wide variety of the NCHS data systems make their first appearance in this series.

In addition, some early results appear in Health, United States, the Secretary of Health and Human Services' annual report to the President and the Congress. Similarly, The Nation's Use of Health Services, a biennial compendium issued by the Center contains some early results.

3. Certain government agencies receive special tabulations prior to the general publication of data. For instance, the Veterans Administration (VA) needs information on the medical care patterns of veterans in order to plan its medical care system. The VA is routinely provided tabulations from the National Health Interview Survey and from other data systems to meet its needs.

4. Public Use Computer Tapes are frequently available for purchase at a nominal fee prior to the extensive publication of tabulations from the particular survey.

It should be noted, in this context, that the United States health statistics are at least as current as those issued by most other nations.

HEALTH STATISTICS

Question: What is the current status of the environmental health study?

Answer: A series of specific responsibilities were assigned to the National Center for Health Statistics (NCHS) under the environmental health provisions of Public Law 95-623. The statutory requirements and NCHS' progress in fulfilling them are:

1. Developing a plan for the collection and coordination of statistical and epidemiological data on the effects of the environment on health (Sec. 306(1) 1). NCHS staff developed the original version of the plan and incorporated the suggestions of, and obtained the concurrence of, the 18 governmental agencies that maintain relevant data systems as well as the several additional organizations specified in Sec. 306(1) 4. In accordance with the statutory requirements, the Secretary of Health and Human Services transmitted the plan to the Congress during fiscal year 1980. Details of planned implementation are still under discussion.

2. The establishment of guidelines for the collection, compilation, analysis, publication, and distribution of statistics and information necessary for determining the effects of employment and indoor and outdoor environmental conditions on the public health (Sec. 306(1) 2). Guidelimes have been drafted by the National Center for Health Statistics staff and have been reviewed by some 21 different agencies. A notice was published in the Federal Register on December 22, 1980 making available the draft guideliens for public comment. The final revisions of the guideliens will be undertaken after the April termination of the public comment period.

3. The development of a clearinghouse for statistics and information with respect to which the (foregoing) guideliens have been established (Sec. 306 (1)(2) D). Since the content of the clearinghouse depends on the guidelines, substantial progress towards the establishment of a clearinghouse must await the formal promulgation of the guidelines. However, an extensive preparatory investigation of clearinghouse activities in other agencies has been performed by the National Center for Health Statistics.

4. The conduct of a study of the issues respecting, and the recommendations for, establishing a Federal system to assist in locating individuals exposed to hazardous substances, to determine theeffect on their health of such exposure and to assist them in obtaining appropriate medical care and treatment (Sec. 306 (1) 3). The Report has been completed by the National Center for Health Statistics and was submitted to the Congress by the Secretary of Health and Human Services January 1981.

5. Initiate, working through the Institute of Medicine of the National Academy of Sciences, an ongoing study of the present and projected future health costs of pollution and other environmental conditions resulting from human activity (Sec. 304(d) 1). The National Center for Health Statistics staff served as resource persons for the Institute of Medicine (IOM) committee that

developed a plan for the ongoing study. The Report of the IOM Committee has been submitted to the Secretary. It is anticipated that the Report will, after Departmental review and comment, be submitted by the Secretary to the Congress by June 1981.

In addition to the foregoing specific responsibilities of NCHS, Public Law 95-623 required more general statistical and epidemiological functions for the National Center for Health Statistics in the environmental health realm. The elucidation of the impact of environmental exposures on individual health and health care is made a central focus of NCHS. Consonant with that mission, NCHS is currently conducting a major epidemiological investigation of the impact of environmental and occupational exposures on the incidence of fetal mortality and on the incidence of low-birthweight live births. The shock of having one's infant born dead is an experience of extreme anguish for the parents. An infant born alive but weighing very little is at high risk of immediate death or imparied functioning. Thus, the investigation of possible environmental hazards with regard to the reproductive process is of top priority.

This inquiry, the 1980 National Natality Survey and the 1980 National Fetal Mortality Survey, is being financially supported by:

. The National Institute for Occupational Safety and Health (Center for Disease Control)

. The Bureau of Radiological Health (Food and Drug Administration)

. The National Institute of Child Health and Human Development (National Institutes of Health)

. The National Institute on Drug Abuse (Alcohol, Drug Abuse, and Mental Health Administration)

. The National Institute on Alcohol Abuse and Alcoholism (Alcohol, Drug Abuse, and Mental Health Administration)

. The Bureau of Community Health Services (Health Services Administration)

This cooperative venture eliminates the need for each of the several agencies to conduct its own natality survey, and consequently eliminates redundant expenditures and respondent burden for surveys of this type. Such joint undertakings provide the most effective mechanism for coordinating statistical activities. We plan more collaborative efforts in the future. The National Death Index is another example of an activity which is being carried out by the National Center for Health Statistics but which serves the entire environmental health research community. The Index permits an investigator to determine whether people exposed to a particular environmental constituent die earlier than would otherwise be expected or not. For example, there is reason to suspect that exposure to certain dry cleaning fluids increases the risk of developing certain types of cancer. Starting with a list of individuals who had been employed in dry cleaning establishments, it would be possible to check the list of individuals against the Death Index to determine whether or not the individual had already died and then to locate the death certificates of the decedents. The Death Index which, following three years of intense developmental activity, should become operational during the next several months will provide an extremely powerful tool for environmental epidemiology being conducted both inside and outside the Federal Government.

Question: What is the current status of the Hispanic Nutrition Studies?

Answer: Preliminary Office of Management and Budget clearance approval has been received covering the conceptual development and content of the proposed Hispanic Health and Nutrition Examination Survey. The Division of Health Examination Statistics and other NCHS staff are preparing the questionnaires and procedures for further review and approval; if the current schedule is maintained, the household questionnaires will be evaluated in several pilot studies beginning in September, 1981. The examination procedures will be evaluated in a pilot study in January-March 1982. The actual study of Hispanics in selected areas of the United States would begin in June, 1982.

During the last year, the Center indicated that the Health Care Financing Administration was to assume a greater role in data collection activities.

Question: In light of advocacy for increased competition and decreased government involvement among health care providers. what new initiatives, if any, are planned for Fiscal 1982?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: To what extent has HCFA increased its role in the data collection process and at what savings to the Department?

Answer: The recent changes in HCFA activity in data collection activities primarily involve the initiation of demonstration projects designed to examine alternative methods of collecting and using hospital discharge and billing data and health facilities data. To date projects are funded in 10-12 States. These efforts are based on earlier projects funded through the Public Health Service. No direct savings to the Department have yet been realized and estimates of such savings will not be available until the results of these early demonstration projects are analyzed and final implementation palns are developed.

Question: Are there plans to encourage other agencies to increase their responsibility in the data collection process?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Health Care Technology

The purpose of the National Center for Health Care Technology (NCHCT) is to assure the most appropriate use of health care technologies (in terms of patient out-come and cost-effectiveness) by conducting assessment activities and providing advice on the appropriate uses of new and existing technologies.

Question: How are your priorities developed?

Answer: The National Center for Health Care Technology (NCHCT or Center), with the assistance of the National Council on Health Care Technology (Council), is responsible for setting the priorities for health care technology assessment, and for final selection of the topics for assessment. The Council has developed criteria that are applied in selecting and setting the priorities for assessment (see attached publication, "Procedures, Priorities and Policy for Assessment of Health Care Technology", prepared by the Council). These criteria include the actual or potential risks and benefits to patients associated with the use of the technology; the actual or potential cost of the technology; the actual or potential rate of its use; the stage of development of the technology; and, the potential for abuse, such as overuse and inappropriate use.

A preliminary review of an identified technology is undertaken to define the important issues it poses and to compare it to other related technologies. The results of this review are utilized to set the priority for a particular technology in the overall technology assessment program. The Council determined that the priority assigned to a particular criterion might vary, depending upon the stage of development of the technology. Accordingly, three categories of development were chosen -- "emerging", "new", and "established" technologies -- and for each a different ordering of priorities was made.

Consistent with its policy of openness and broad participation, the Center consults in the priority-setting and selection processes with a wide variety of parties and groups in both the public and private sectors. Recommendations regarding condidate topics for technology assessment are made by a number of individuals and groups, including the Council, the Department of Health and Human Services (DHHS) Technology Coordinating Committee, Federal agencies outside the DHHS, the Office of the Assistant Secretary for Health, the Office of the Secretary, the Congress, medical and other professional health ralated groups in the private sector, and the public. With the large number of potential topics for assessment, setting specific priorities is essential.

Question: How has the Center's program had the most impact over the past year in preventing overuse of technological advances, and in avoiding the use of poorly-developed technological devices?

Answer: While the National Center for Health Care Technology (NCHCT or Center) has not singularly been responsible for preventing overuse of technological advances or avoiding the use of poorly-developed technological advances, it has provided information for and has played a coordinating role in departmental policy decisionmaking on whether or not the use of particular technologies should be promoted. To date, the Center's greatest and most immediate impact has been through its provision of scientific and medical advice to the Health Care Financing Administration (HCFA) on Medicare coverage issues. These issues are questions raised by HCFA regarding the safety and efficacy of particular medical items, procedures, or services and the appropriateness of their reimbursement Medicare. HCFA uses this advice in determining coverage policy for the particular technology and in developing reimbursement instructions for Medicare carriers and fiscal intermediaries.

In evaluating Medicare coverage issues the Center ensures that practicing physicians, clinicains in the research community, other investigators from a wide range of biomedical and behavioral disciplines, representatives of the health industry, members of the general public, and other participate actively in the assessment process at appropriate stages. The Center also obtains information and advice from one or more of the agencies represented on the Department of Health and Human Services (DHHS or Department) Technology Coordinating Committee (TCC), as appropriate, and from representatives of extra-governmental groups, such as medical specialty societies and manufacturing organizations.

Through its evaluations and recommendations on Medicare coverage issues, the Center may impact on both the quality and cost of health care. For example, if HCFA implements an NCHCT recommendation and extends coverage to an item or procedure which has been demonstrated to be safe and effective, the quality of care is enhanced. If such an item or procedure replaces a more complex and costly procedure, money is saved. Conversely, if the NCHCT finds that a treatment or service is unproven, based upon an evaluation of the data, the overall quality of care is improved for Medicare beneficiaries and money is saved when HCFA determines not to reimburse. It should be pointed out that the Center plans to publish (at the invitation of the Editor) in the Journal of the American Medical Association for the information of the practicing community and the public, the substance of the evaluations it provides HCFA. Consistent with its policy of openness, the basis for any particular recommendation also will be made public by the Center. Accordingly, the results of the Center's evaluations can also be used by private third-party payors in their decision-making on reimbursement policy.

It should be pointed out that, as it becomes available at various points in the assessment process, the NCHCT dissemminates for timely use in the practice setting evaluative and other pertinent information about particular technologies. For example, as a derivative of its current assessment activities pertaining to ESRD, the Center had an integral role in the development of the Surgeon General's advisory statement, "Treatment of Water for Use in Dialysis; Artificial Kidney Treatments" that was published by the Public Health Service in June 1980.

Question: Please highlight the Center's recommendations to HCFA on Medicare coverage issues and associated savings during the last year.

Answer: The Medicare coverage issues on which the NCHCT has provided advice to HCFA span the full spectrum of medical practice, from obsolete practices to new, or in certain cases, investigative technologies. In fiscal year 1980, the Center provided HCFA with evaluations and recommendations on a total of 38 coverage issues. Of these, the Center reocmmended non-reimbursement for 15 technologies. To date, HCFA has issued national coverage instructions on approximately half of the 38 technologies on which the NCHCT provided evaluations and recommendations in fiscal year 1980.

Two groups of researchers and economists, one at Harvard University (directed by Dr. Howard Frazier, Director, Center for the Analysis of Health Practices) and the other at UCLA (directed by Dr. S. O. Schweitzer, Director, Program in Health Planning and Policy Analysis), have developed methodologies to estimate the cost impacts of Medicare coverage decisions, and have applied these methodologies in estimating the impact on costs of several NCHCT recommendations that certain technologies not be reimbursed under Medicare. The findings of the Harvard study show that the NCHCT recommendations on Medicare coverage issues can result in significant cost savings to the Federal government and society as a whole.

In their study, the Harvard group focused on four new medical technologies which the NCHCT had recommended not be covered under Medicare: endothelial cell photography (specular micoscopy of the cornea, providing high-magnification photographs of the cornel endothelium, the layer of cells along the inner surface of the cornea); dialysis for schizophrenia (clinical management of schizophrenic patients through dialysis of the blood); hypothermia for cancer (treatment of malignant disease by elevating the temperature of the entire or selected areas of the body); and, radial keratotomy for myopia (microsurgery to remold the cornea of the eye to correct a refractive error, near-sightedness). As reflected in the following chart, the Harvard group estimated that for the Medicare program alone, non-reimbursement of these therapies could save $88 million to $959 million over a ten-year period. They also projected that if the NCHCT's recommendations for non-reimbursement of these technologies were adopted throughout the health care system, $471 million to $2.554 billion could be saved within that same time frame.

SUMMARY OF TEN-YEAR SAVINGS EXPECTED FROM CURRENT DECISIONS NOT TO REIMBURSE

(MILLIONS OF DOLLARS*)

	Medicare Population (Age 65)			U.S. Population (All Ages)		
	Low Estimate	Middle Estimate	High Estimate	Low Estimate	Middle Estimate	High Estimate
Endothelia Cell Photography	45	105	350	55	130	450
Dialysis for Schizophrenia	8	29	150	39	146	750
Hyperthermia for Cancer	25	163	440	42	272	734
Radial Keratotomy for Myopia**	10	15	19	335	477	620
TOTAL	88	312	959	471	1025	2554

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*Present Value, 1980 Dollars

**Two sets of diffusion assumptions were examined; the results are shown as High and Low Estimates. The Middle Estimate is the arithmetic mean of the two.

Question: Please comment on the Center's relationship to other Department components.

Answer: Within the Department of Health and Human Services (DHHS or Department), the National Center for Health Care Technology (NCHCT or Center) is the focal point for coordinating departmental activities pertaining to health care technologies and their assessment. The principal mechanism through which the Center achieves this coordination is the DHHS Technology Coordinating Committee (TCC). The TCC, which includes representation from all agencies of the Public Health Service (PHS), the Health Care Financing Administration (HCFA), and a number of agencies outside the DHHS, has been meeting regularly since the Center began operations early in 1979. The Mandate for the TCC, which instituted formally the role of the TCC in the Department, was signed by former Secretary Harris in November 1980. Thus, for the first time, the DHHS, and indeed the Executive Branch, has a formal coordinating mechanism and forum for identifying and discussing departmental issues associated with health care technologies; information exchange and interagency cooperation on health care technology matters; and, joint action on relevant issues.

The TCC also serves as an internal departmental advisory body to the NCHCT Director on matters pertaining to NCHCT programs and activities. Agencies represented on the TCC also assist and collaborate with the NCHCT in planning and conducting health care technology assessments within the scope of their authority and mandates, to the extent that resources are available. The TCC also makes recommendations to the NCHCT Director on such matters as:

1. means of improving coordination among DHHS components, other Federal agencies, and State and local agencies in activities pertaining to health care technology;
2. the dissemination of information pertaining to assessments of health care technologies;
3. the implementation of recommendations derived from assessments of health care technologies;
4. the identification and selection of technologies for assessment;
5. the provision of advice to the Health Care Financing Administration (HCFA) on Medicare coverage issues; and,
6. the identification of newly emerging technologies.

The TCC is chaired by the Director of the NCHCT and includes representatives of the Food and Drug Administration (FDA); HCFA; Centers for Disease Control (CDC); National Institutes of Health (NIH); Health Services Administration (HSA); Health Resources Administration (HRA; Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA; National Center for Health Services Research (NCHSR); and, the National Center for Health Statisitics (NCHS). It also includes liaison representation from the Office of the Secretary (OS), the Offices of the General Counsel (OGC) and Inspector General (OIG) in OS, the Office of the Assistant Secretary for Health (OASH), and the Office of Health Research, Statistics, and Technology (OHRST). Other Federal offices, agencies, and departments with interests in health care technology also are represented; they include, for example, the congressional Office of Technology Assessment (OTA); the Office of Science and Technology Policy (OSTP) in the Executive Office of the President; the Veterans Administration; the National Institute of Handicapped Research (NIHR) in the Department of Education (DE); and the Department of Energy (DOE). The National Aeronautics and Space Administration (NASA) and the National Bureau of Standards (NBS) also will be invited to participate in the TCC.

In addition to their representation on the TCC, certain Federal agencies and programs also have ex officio representation on the National Council on Health Care Technology (Council). The Council fulfills a number of advisory functions in conjunction with the programs of the NCHCT. The heads of the NIH, CDC, HCFA, FDA, and OSTP are ex officio members of the Council, as are the Chief Medical Officer of the VA, the Assistant Secretary for Health and Environment of the Department of Defense (DOD), the Chairman of the National Professional Standards Review Council, and the Chairman of the National Council on Health Planning and Development.

In discharging its responsibilities the NCHCT draws upon the strengths and expertise of other agencies of the Public Health Service (PHS), and, when indicated, upon other Federal agencies as well. When appropriate, the Center complements or cosponsors health care technology assessments conducted by other Federal agencies. In its evaluations of the appropriateness of Medicare coverage for particular health care technologies, in response to HCFA requests for PHS guidance on coverage policy, the NCHCT relies heavily on the medical and scientific advice which is provided to it by other PHS agencies such as the NIH, FDA, CDC, and ADAMHA. With regard to the Medicare coverage determinations process, the PHS and HCFA have negotiated successfully a Memorandum of Understanding (MOU) which delineates, formalizes, and strengthens the relationship between the two agencies in this activity. Another MOU, between the NIH/Office for Medical Applications of Research (OMAR) and the OHRST/NCHCT, is being developed to delineate and clarify the role functions of these agencies as they pertain to health care technology assessment.

HEALTH MAINTENANCE ORGANIZATIONS

Question: In terms of HMOs acting as a "restraining influence on rising medical costs", what consideration has been given to a Federal assistance formula characterized by higher proportional payments to those HMOs experiencing lower hospital costs and, conversely, a lower proportional share to high costs HMOs?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

It is the Subcommittee's understanding that HMO legislation proposals accompanying the Carter budget include the elimination of the special annual 20% set-aside for rural HMO projects. It is further observed that the Carter budget reflects an anticipated $8.7 million carry over from the FY 1981 non-metropolitan set-aside balance.

Question: Does the Reagan Administration concur in these proposed policy changes?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: By reducing rural HMO projects, is the HMO program not failing one of its primary objectives to increase the access to high quality care for all Americans?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: In light of increasing support for metropolitan HMOs by private industry, why is the Department turning away from support of rural areas which are not being supported by the private sector?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

HMO LOAN GUARANTEE FUND

The HMO Loan and Loan Guarantee funds authorized loans to HMO's to make up any operating deficit during their first five years of operation provided the Secretary is "reasonably satisfied" the loan will be repaid. The budget indicates default losses of $45.2 million in this program during 1981 and 1982; or about 33 percent of the $135 million in loans outstanding at the end of 1980.

Question: Did the Secretary contemplate losses of this magnitude when the loans were made? If so, how does this square with the requirement that the Secretary be "reasonably satisfied" that the loans will be repaid as required under Section 1308(B)(1) of the Public Health Service Act?

Answer: The possibility of losses in the loan fund were considered when the program was established. The magnitude of the loss was not possible to estimate because HMO's are complex businesses competing in highly competitive marketplaces. They are high risk ventures and as such we were aware of the possibility that some will fail.

Before Federal loans are granted we carefully analyze the application to assess the reasonableness of the enrollment projections, utilization assumptions, and cost assumptions. Further, an indepth analysis of the HMO's management is undertaken to determine the capability of management to achieve the objectives of the financial plan. The results of this prospective analysis provides us with a rationale for approval or denial.

Question: If losses of this magnitude were not anticipated when the loans were originally made, what happened in the intervening period?

Answer: There are a number of problems encountered by HMO's contributing to their failure that could not be clearly identified before operations. We have seen operational problems resulting from premiums underpriced and not adjusted to reflect actual cost of operations; enrollment projections not achieved, due to inadequate sales approaches and/or changes in the marketplace not adequately responded to be the HMO; health care costs underestimated and inadequate utilization controls; and increases in fixed costs beyond the financial ability of the HMO to pay for them through premiums.

Question: Wouldn't it make more sense to recongnize reality and convert the loan program into a grant program?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What portion of the loans outstanding in 1980, 1981, and 1982 are to finance operating deficits and what portion is to finance the construction of facilities or the acquisition of equipment?

Answer: All of the loans outstanding in 1980 were made to finance operating deficits. The following amounts are budgeted for FY 1981 and 1982.

	FY 1981	FY 1982
Operating loans	$51 million	$67 million
Facilities loans	5 million	12 million

Question: Why are you contemplating a discount loss on loans sold to the Federal Financing Bank (FFB)? Why cannot the rate on these loans be tied to the going rate on FFB loans at the time they are sold?

Answer: Loan commitments are made to HMO's for the full amount of deficit financing projected during the first 60 months of the HMO's operation. The statute restricts yearly disbursements on a loan to no more than $2.0 million. Before the 1978 amendments, this restriction was $1.0. Therefore, since the total loan often exceeds $2.0 million, multiple yearly disbursements to the HMO are necessary. The statute further requires that each yearly disbursement be at a constant interest rate established at the time the loan was originally made.

Loans disbursed to HMO's are sold from time-to-time to the FFB to revolve the capital in the fund. Sales discounts or premiums occur based on the difference between the prevailing interest rate at the time of sale and the rate set on the loan. During the recent past, interest rates have increased markedly resulting in discount losses on sales to the FFB. The loans being disbursed today were made many months ago when interest rates were 9 and 10 percent. Each sale today, with interest rates between 13 and 14 percent on the average, results in almost a 30 percent discount.

HMO LOAN FUND

The HMO loan fund is reported to be at a dangerously low level. Loan defaults have drained the fund, and the Department has requested a $17 million fiscal 1981 supplemental to keep the fund from running dry.

Question: Since the HMO Act was enacted in 1973, how much has the Federal government awarded to HMO's in loans?

Answer: Through December 31, 1980, the Office of Health Maintenenace Organizations has awarded $176 million in loans. A total of $152 million has been disbursed on these loans with the remaining $24 million to be disbursed through FY 1983.

Question: How many HMO's have received these loans?

Answer: Through December 31, 1980 there were 85 HMO's who have been awarded Federal loans for operating cost assistance.

Question: How many HMO's that have received Federal assistance are presently paying off their loans?

Answer: Each HMO awarded a Federal loan is required to pay semiannually interest on the amount disbursed starting with the initial disbursement. Annual principal payments are not required until the first year after the HMO projects breakeven. Thereafter, the loan is repaid over a period of approximately 17 years.

Through December 1980, there have been 85 HMO's awarded loans. Ten of these HMO's have gone out of business. Of the remaining 75 HMO's 12 are repaying principal as scheduled. In FY 1981, 12 additional HMO's will begin principal payments on their loans.

Question: How many HMO's that have received Federal assistance have gone out of operation?

Answer: As of December 31, 1980, ten HMO's who have received Federal assistance have gone out of business and their loans have been declared uncollectible. The face value of these loans is $19.8 million. We anticipate recovering approximately $700,000 when liquidation proceedings are completed by the court.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

The FY 1982 Carter budget reflects a 32 percent increase over FY 1981 for Management Training and Technical Assistance. This funding is intended to expedite development activities and resolve operating problems encountered by HMO's.

Question: What has been the incidence of financial turnaround fo HMO's directly and indirectly attributable to teams of experts sent in to provide technical assistance? Please be specific.

Answer: The major technical assistance efforts have only been operational for little more than a year. It is still too early to determine the full impact of this aid on the effected HMO's. However, 21 HMO's have been assisted under the consolidated technical assistance contract. This particular contract involved sending in a team of experts, consisting of experienced HMO managers, who provided and directed the assistance. Of the 21 plans assisted; 12 plans have already benefited in some way from this effort; 7 are still receiving assistance; and 2 essentially did not appear to utilize assistance to their advantage. Specifically, (1) the Community Health Plan of Suffolk in Hauppauge, New York appears to have turned around its financial situation based on recommendations for plan reorganization, personnel policy changes, and systems changes from the consultant team. (2) Healthwise in Beckley, West Virginia received help in marketing, finance and utilization control. As a result, the Plan has made significant changes in physicians contracts which should reduce health care costs. The marketing program has significantly improved as have the utilization controls. The Plan's financial position is also beginning to show signs of improvement. (3) Another example is the Marion Health Foundation in Marion, Ohio, where the significant problem was controlling health care costs and, particularly, the need for utilization review and controls. The assistance provided by the expert physicians in the area of utilization control has already begun to have an impact on an improved financial condition ot the Plan.

Question: Has financial stability of those HMO's receiving technical assistance been sustained following withdrawal of teams of experts?

Answer: The assistance to many Plans is either still ongoing or recently completed. However, there are a few instances where assistance is no longer being provided and there has been an apparent ongoing impact. For example, the New Haven Community Health Plan received broad based assistance in management, marketing, health service delivery, and rate setting and MIS. The team is no longer active with the project, but the implementation of many of the recommendations is having positive results.

Question: What has been the incidence of financal turnaround of HMO's whose management has received training through the National HMO Management Fellows Program and/or the HMO Management Seminar Series?

Answer: To date there has been no measurable effect because the first group of 32 HMO Management Fellows began the intensive eight-month training program on January 5, 1981. Training for this group will conclude in mid-August 1981. The second group of 26 Fellows will begin their training March 16, 1981 and conclude in mid-October. Obviously, they have not yet entered the ranks of active HMO managers and have had no impact on the field. The HMO Management Seminar Series, implemented a year ago, is designed to improve the management skills of existing HMO managers in such areas as marketing, financial planning, selling skills, governing board responsibilities, and management information systems. It is difficult to attribute these improvement in individual skills directly to improvements in organizational performance in such a short time.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

In the report accompanying HR 7998, Labor-HHH-Education Appropriations for FY 1981, the House of Representatives requested a report from the Department describing the criteria utilized in determining whether or not a given market area can support a new Health Maintenance Organization.

Question: What is the status of the report?

Answer: The report requested, entitled Federal Support for New Starts in Communities was forwarded to the House Subcommittee on Labor, Health and Human Services, Education, and Related Agencies on February 2, 1981.

Question: What are the advantages and disadvantages of establishing HMO's in geographic areas where another HMO already exists?

Answer: One of the objectives of the HMO program is to establish HMO's as a competitive force to reduce health care costs. In order for this competitive force to exist and have an impact on costs, there must be a "critical mass" of HMO activity in the geographic area so that the fee-for-service system will react to the HMO's competitive cost pressure. The level of HMO activity relates to both penetration of the market and the number of HMO's involved in penetrating the market. When HMO's penetrate about 5-10 percent of the population in the market, they begin to create competitive pressures. Large metropolitan areas, i.e., with over three-quarters of a million people, usually require at least two and sometimes more HMO's to reach this critical penetration level. On the other hand, should a geopraphic area become so saturated with HMO's that the population size connot support the enrollment needed by these HMO's to breakeven, the competitive advantages may be compromised. If each HMO cannot achieve its enrollment to breakeven because the marketplace is over-saturated, then there may be serious questions regarding the ability of each HMO to remain financially solvent.

Question: At what potential membership number does an HMO become financially feasible?

Answer: The membership number needed by an HMO to breakeven depends on a number of factors. The most significant factor is the administrative cost structure required to operate the HMO. The highly contralized HMO's such as staff models, require high levels of administrative cost, therefore, generally requiring membership numbers above 25,000 members to breakeven.

Question: Does the minimum populations base needed to support an HMO vary for staff-model HMO's, individual practice-model HMO's and group practice HMO's?

Answer: The higher the level of membership needed to breakeven, the greater the population base must be to secure the needed members. The more highly centralized HMO's, such as staff and group models, need membership numbers above 25,000 to breakeven. Generally this requires a minimum population base of at least 250,000 to 500,000. Clearly, an HMO is more apt to secure the members required to breakeven in a much larger population base.

Question: Please make a comparison of the performance of the different types of HMO's (individual practice, group practice and staff models) according to different demographic settings.

Answer: Population bases under approximately 500,000 are generally more viable for less centralized HMO's such as individual practice models. Marketing an HMO in a small population base can be difficult especially if the normal access patterns have to change from a broad group of community physicians to a small group organized for a staff or group model HMO. If the population base is not only small but also spread over a large geographic area such as in a rural or nonmetropolitan area, financial viability is more probable if the HMO's product includes access to a broad group of community physicians rather than a select few.

Although the IPA model may have a market advantage because of the spread of physicians available to members, this model's decentralized structure makes it more difficult to effectively manage economic utilization of health service resources. The more centralized staff and group model HMO's have less difficulty managing utilization with the principal physicians working closely with each other in the same facility. However, the staff and group models have a disadvantage in marketing their product which is a limitation on access to only the physicians in the HMO.

HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

The new Congress will most likely be considering whether to keep mandated community rating for reimbursements when the HMO law comes up for renewal this year.

In addition to community rating, several different rating practices are possible. The responses to the following questions are based on the following definitions:

Community Rate

Same premium for the same benefits to all individuals or groups, regardless of age, sex composition and cost experience of the insured.

Experience Rate

Premium charged varies with the cost experience of each group covered. (Members of some groups pay higher premiums than members of other groups.)

Actuarial Rate (adjusted community rating)

Premium charged to different segments of the community reflects actuarial categories and the community rate is adjusted according to measures associated with utilization.

Demographically Adjusted Rate (a subset of actuarial rate)

Premium charged reflects a profile of a group based on demographic factors -- usually age and sex.

Question: What are the advantages and disadvantages of community rating?

Answer: Advantages of community rating:

1. HMO achieves maximum stability and predictability of rate revenues.

2. Community rate minimizes administrative costs to HMO's.

3. Community rating permits increased accessibility to HMO's for high risk individuals and groups who might not otherwise be able to afford enrollment in an HMO.

4. Community rate spreads cost of health care across larger population groups.

5. Community rating is a major distinguishing characteristic of HMO's as compared with traditional insurance carriers.
6. Community rating is compatible with an HMO's basic economic structure and is closely linked to the HMO's financial incentive mechanisms.
7. The variation in utilization experience that lends some justification to experience rating in traditional insurance is unlikely to be as significant a factor in HMO's where all members receive service within the same organized system.
8. Community rating focuses competition on cost instead of risk selection.

Disadvantages of community rating:

1. HMO competitors are not required to set their rates on a community rated basis.
2. HMO's can be subject to adverse selection if sicker people are charged the same rate as healthy people.
3. Community rating is an inappropriate mechanism for achieving social objectives (taxes in the form of transit payments would be more effective).
4. An HMO with a single community rate can't be competitive in both high and low cost markets.

Question: What are the advantages and disadvantages of establishing premiums that are demographically determined?

Answer: Advantages of demographically adjusted rates:

1. Prospectivity of rate setting is retained.
2. Rates don't reflect actual cost of services used.
3. Permits HMO to charge higher rates for a group whose demographic profile indicates higher utilization.

Disadvantages of demographically adjusted rates:

1. Demographic variables are crude proxies for probable health risk.
2. Unclear whether resulting premiums would be equitable or valid due to questionable reliability of demographic variables such as age and sex.
3. Demographically adjusted rate is not likely to result in improvement in restricting access to high risk individuals and groups.

Question: What are the advantages and disadvantages of actuarial (adjusted community) rating?

Answer: Advantages of actuarial rating:

1. HMO's can enroll and care for high risk people without being penalized for doing so.

2. Rating according to broad risk categories would minimize the perverse impact on an HMO's financial incentive system of a strict experience rates approach.

3. Represents an attempt to prospectively define broad categories of risk.

4. Would probably be relatively simple to administer.

Disadvantages of actuarial rating:

1. Sicker people who may not be able to afford higher costs associated with higher utilization may not be able to afford HMO membership if actuarial rating is permitted.

2. Unless all insurers are required to fix their rates under the same system, HMO is subject to unfair restriction with regard to its rating practices.

3. Doesn't require HMO to use savings realized from greater cost-effectiveness or efficiency for spreading cost of care over a large cross-section of the population.

Question: Is there a study comparing the relative equity of one type of premium rating over another for the different types of HMO's (individual practice, group practice, and staff models)? Please elaborate.

Answer: We do not know of any study which compares the effect of various rating practices on different model HMO's. We would point out, however, that since all federally qualified HMO's are required to fix their rates in the same manner (i.e., based on a community rate), this type of comparison may not reveal significant findings. Perhaps a more telling comparison would be the effect of various rating practices if mandated on only one type of insurer (e.g., HMO's) and not on all competitors in the same field.

ADOLESCENT HEALTH

The enacting legislation of the Adolescent Pregnancy Program includes Title VIII directing that a contract be awarded to conduct a comprehensive study of adolescent pregnancy and Federal response to it. This study was to have been completed and submitted to Congress by November, 1979.

Question: To date, no report has been received by Congress. When can it be expected, and why has it been delayed?

Answer: The original due date for the report was November 10, 1979. The study authorized by the legislation was not conducted because funds were not appropriated to the Office of Adolescent Pregnancy Programs until July 3, 1979. In addition, these funds were not sufficient to conduct the study and to carry out the established goals and objectives of the office.

It was anticipated that after funds were appropriated in FY 1980, a contract would be awarded and the report of the study's findings would be submitted to the Congress on or about January 15, 1981. Letters advising the Congress of this new date were sent on October 5, 1979.

It was determined, however, that the report would not be completed by the revised due date to the Congress because of delays in awarding the contract to conduct the study prior to September 1980. This was due to a number of administrative delays in processing the Request for Proposal (RFP) for the contract. The contract has now been awarded and calls for a 12-month study which is estimated to be completed by the end of September 1981. The final report from the contractor is to be submitted one month after the study is completed. The report to Congress, which will be based on the final report to the Office of Adolescent Pregnancy Programs, will take one month to prepare. The PHS and OS reviews take twelve weeks. Therefore, the proposed timetable is as follows:

Contract Awarded - End of September, 1980
Study Completed - End of September, 1981
Final Report Submitted - End of October, 1981
OAPP Written Report to the Congress - End of November, 1981
Review within PHS - December 15, 1981
Review within OS - End of February, 1982
Possible Times Needed for Revision or Rewrite - End of March, 1982
Report Submitted to the Congress - April, 1982

The Department of Health and Human Services is now developing its final version of model adoption law for the Model State Adoption Act.

Question: What part, if any, does the Adolescent Health Office have in determining the final regulations for the law?

Answer: To this date, OAPP has not been involved in the development or review of these regulations. However, it has been customary for regulations that might impact on adolescent pregnancy programs to be forwarded to OAPP for review and comment, and it is anticipated that this will occur with the Model State Adoption Act regulations.

SERVICES OF ADOLESCENT PREGNANCY PROGRAM

Question: It is the Subcommittee's understanding that some of the adolescent pregnancy programs integrate parenting education programs with day care activities.

Answer: Education for parenting is an integral part of all comprehensive programs funded under Title VI of Public Law 95-626. In some instances where it is possible to have child care facilities, there are opportunities for adolescents who are non-parents as well as those who are parents to participate in parenting education classes. These classes often involve male as well as female participants.

Question: How many teenage mothers give up their illegitimate babies for adoption?

Answer: Approximately 94 percent of teenage mothers keep their babies. About 2.5 percent send the baby to live with relatives or friends. Only 3.5 percent relinquish their babies for adoption. These figures include married as well as single mothers. Of the unmarried pregnant teenagers, five percent place the baby with relatives or friends, and about eight percent relinquish their infants for adoption.

Question: What percentage of these pregnancies are generally considered high risk?

Answer: Unmarried mothers are more likely than married mothers to bear a low-birth-weight baby. Girls under 15 years of age have the highest risk of any age group of bearing a low-birth-weight, high-risk baby. The overall incidence for girls 15-19 years exceeds that for all older age groups except women 45-49 years old. This risk of low birth weight for infants born to teenage mothers diminishes with each successive year of age -- from 14.8 percent for infants born to girls under 15 years of age to 8.8 percent for those born to 19-year-olds.

Question: What percentage of these teenagers have health insurance that covers maternity?

Answer: The only study of health insurance coverage for maternity is a 1972 survey by the National Center for Health Statistics. However, it includes only information on births to married women, which would, therefore, not include most teenage births. Teenagers usually do not have separate health insurance coverage but come under coverage held by their parents or guardians. Legally, such coverage for a teenage birth would be allowed only after the ninth month of pregnancy or after the baby is born.

Question: How late in the pregnancy do these young mothers seek the help of program grantees?

Answer: Most comprehensive programs try to enroll young women during their first trimester of pregnancy. On-going, established programs usually are able to do this because their services are known in the community. For newer programs that have yet to establish their credibility, enrollment may be later. There are currently no hard data on this question. OAPP's evaluation study will help to verify this information.

PREGNANCY PREVENTION

One objective of the Adolescent Health program has been to prevent initial and repeated pregnancy among adolescents.

Question: What program have you developed to more effectively motivate young adolescents either to refrain from sexual activity or to use contraceptives?

Answer: The intent of P.L. 95-626 is to develop comprehensive programs that will enable young people to handle their sexuality in a responsible manner. In order to accomplish this goal, OAPP technical assistance efforts emphasize the importance of including opportunities for extended family members to participate in program as well as helping young people make responsible decisions in relation to how they use their sexuality.

Approximately 40,000 adolescents are served through the OAPP funded programs. Services to non-pregnant adolescents represent 64 percent of this number.

Services to non-pregnant adolescents include programs where the families of the adolescents are involved. Programs also try to help adolescents develop positive self concepts and try to help them understand their human sexuality and use it in a responsible way.

Question: What other innovations and evaluations have been performed by the projects you have funded?

Answer: As mandated by the legislation, each funded OAPP program is expected to do an annual self-evaluation. In addition, under Title VII of the legislation, an independent evaluation study is being conducted by the Urban Institute of Washington, D.C. All of the comprehensive programs funded by OAPP are required to include 10 core services. They are encouraged to design innovative approaches to these services. Some programs have initiated special classes to increase self-esteem and communications skills. They feature role playing for job interviews and practice sessions on developing skills in letter writing and filling out of application forms. They stress self-image improvement through dance and movement classes and arts encounter programs. Others have Big Sisters and Big Brothers as role models and classes where parents participate in family encounter groups.

PHYSICAL FITNESS AND SPORTS

The Congress appropriated funds for Fiscal 1981 to the President's Council on Physical Fitness and Sports to study the status of the physical fitness and health of elementary and secondary school children.

Question: What is the status of the project to determine the physical fitness level of elementary and secondary school children?

Answer: Scientific reports on the physical fitness levels and practices of youth were presented at the National Conference on Physical Fitness and Sports for All. At that time the President spoke and set forth recommendations for the country which supported greater study and attention to school physical education programs. Recommendations were then sent to the Secretary of Education for consideration. It was proposed that the National Center for Educational Statistics update the previous norms. The Surgeon General's objectives for 1990 for health promotion/disease prevention included physical fitness goals of school-age children. The PCPFS is the lead agency for the development of HHS plans to reach those physical fitness and exercise objectives.

The Physical Fitness and Sports program has requested a 36 percent increase in funding over Fiscal 1981.

Question: What new initiatives does the program anticipate in Fiscal 1982? What would be eliminated if the budget were held 10 percent below last year's budget?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What are the highlights of the program during the past year?

Answer: 1) Conducted the first National Conference on Physical Fitness and Sports for All, called by the President and attended by over 1,000 delegates.

2) Conducted the first White House Symposium on Physical Fitness and Sports Medicine, directed at primary care physicians.

3) Fitness (public information) materials were provided to 700 TV stations, 8,000 radio stations, 2,400 general circulation magazines, and 3,100 specialized journals (business press).

4) A direct-mail campaign reached 103,000+ schools, recreation departments, Y's, Boys' Clubs, Jewish Community Centers, and other youth-serving agencies.

5) New publications included: ONE STEP AT A TIME (Running Book), PHYSICAL EDUCATION: A PERFORMANCE CHECKLIST, FITNESS IN THE WORKPLACE, WALKING, BICYCLING, FLEXIBILITY, MUSCULAR STRENGTH.

6) Workshops for training exercise and "Sports for All" leaders were held in 14 different locations with more than 10,000 persons participating.

7) More than 20 million youth participated in the Presidential Physical Fitness Award Program, and the President received the 5 millionth winner in a ceremony at the White House.

8) 1.3 million persons aged 15 years and older participated in the Presidential Sports Award Program.

9) Seven new Governors' Councils on Physical Fitness and Sports were either formed or reorganized.

10) More than 40 million Americans participated in various programs of the Council.

11) Most of the PCPFS programs were cosponsored with and funded by the private sector.

12) Frequency of participation in exercise has grown from 24% to 60% in 1979. The intensity of participation is also at an all-time high. One out of every nine Americans is a runner, and one out of every four runners covers at least two miles per day.

13) Membership in the American Association of Fitness Directors in Business and Industry (AAFDBI), a PCPFS affiliate, has increased from 24 in 1975 to 1900 today. Over 3,000 businesses, industries and government agencies provide health/fitness programs for the workforce at the workplace.

14) Council staff members worked with nearly 400 corporations and 11 federal agencies in the development of leadership facilities and programs for employee health/fitness.

Question: Cite studies and give an example of business and corporation sponsored physical fitness programs that have increased health and productivity of employees.

Answer: The International Congress for Fitness and Trim reported research done at the Goodyear plant in Norrkopking, Sweden, which showed absenteeism among participants in their program fell by nearly half. NASA Headquarters in Washington, D.C. conducted a research program in cooperation with the Heart Disease and Stroke Control Program of the Public Health Service. Nearly all the regular participants said they felt better; 89% reported improved stamina; and nearly half of the number reported sounder sleep. Many participants quit smoking or cut down, and nearly half said they were paying more attention to their diets. The 5-year experience involved 847 employees, both male and female, which resulted in favorable modification in risk factors, amelioration of health problems in reduction in employee absenteeism. Cost of the program was calculated at $40/employee/year. Fifty-five percent of those participants charged more sick leave during their control year than during their program year, which means 62.8 hours and 36.1 hours from the respective control program years. The mean sick leave hours for all program participants in their program year (46.5) were substantially below the mean sick leave hours reported for all New York State employees during the same year (73.5).

Significant reductions in serum cholesterol, body weight, tobacco consumption, and both systolic and diastolic blood pressure contributed to the reductions in risk factor scores, manifested following pre- versus post-risk factor assessment. Relative composition of body weight was also improved with a significant reduction in percent fat demonstrated by male participants. All of these objective changes, coupled with the increased physical activity status of the participant, contributed to the reduced risk factor score manifested by 86% of those employees completing one year of active participation.

Research done on employee fitness programs at CMINCO in Vancouver and INCO in Sudbury, Canada showed participants increased fitness, decreased resting heart rates and decreased body fat.

A recently completed report in the Province of Ontario, "The Relationship Between Physical Fitness and the Cost of Health Care," relates the physical fitness of participants to their health care cost, as measured by the frequency of doctor and hospital visits, numbers of days off due to illness and the amount of physician claims made under the Ontario Health Insurance Plan.

In conclusion, it is fair to say that the formal research documenting the effects of employee health/fitness programs in the workplace are insufficient to draw concrete conclusions. Certain basic assumptions for action can be made on the basis of research findings. Principally, that a lean, fit workforce is less ill, more productive and enjoys a better quality of life than an overweight, sedantary workforce. The extent to which health care cost represents a major debt to American industry and significantly detracts from worker productivity, low cost employee health/fitness programs make excellent economic sense as a modest, effective investment in the prevention of disease and disability. These programs must be an essential component of the national preventive health program; and any serious effort to improve the living habits which ultimately disable or kill so many American workers must include a serious commitment to employee health/fitness programs.

Question: How many States and schools participated in the State Campion project in 1980?

Answer: Nine hundred and fifty schools in 50 States and the D.C.

Question: What percentage of your expenses are travel expenses?

Answer: Six and one-half percent (6½).

Question: What efforts have been made to reduce travel expenses by expanding use of telecommunications and video, especially for demonstration and training?

Answer: The PCPFS conducts Regional Clinics on Physical Fitness and Sports. The audience ranges between 500 and 1000 in size. Most of the training sessions consist of participation and/or "hands on" demonstrations. Budget restrictions limit the potential of using video tapes for mass training.

Question: What methods of outreach do you use to involve poor populations and rural populations in your programs?

Answer: In addition to our national media campaign, schools and recreation departments are the major vehicles for involving these populations. We have done work with the Indian ancestory. Examples of the school programs are the Presidential Physical Fitness Award, State Champion and Demonstration Center programs.

Question: How are the priorities of the international health office established?

Answer: The Office of International Health (OIH) plays a key role in the establishment of priorities for international health cooperation for the entire Public Health Service, not just for the Office itself. In this regard, priorities are determined by various factors, including foreign policy considerations, opportunities to increase knowledge in the health sciences and humanitarian concerns.

The Office provides, on a continuing basis, policy direction and advice regarding program development and maintenance to the PHS Agencies. The guidance regarding priorities encompasses regional and/or country emphasis; desirable substantive emphasis, based on knowledge of regional and country-specific health problems and priorities and related PHS capabilities and interests; and mechanisms for cooperation. The OIH guidance on priorities reflects a careful consideration, in cooperation with the PHS Agencies and other Federal Agencies (DOS, AID, Treasury), of all factors bearing on the desirability of and potential for cooperation with other countries.

During the past decade, the PHS priorities for international cooperation have been influenced considerably by U.S. foreign policy initiatives. This influence on the international health priorities is a reflection of the very high esteem in which the U.S. health science community is held throughout the world and the ever increasing rate at which other countries have been seeking cooperative health relationships with the United States. Important examples of binational health programs which were developed as part of overall U.S. efforts to improve U.S. relationships with selected countries are those with the U.S.S.R., the People's Republic of China, Japan, and Egypt. In addition to furthering U.S. foreign policy objectives, these programs are serving U.S. scientific interests well, reflecting the firm scientific base on which they were founded.

Question: Please highlight the major projects of the past year, and new initiatives underway.

Answer: In January 1980, a U.S.-Israel Health Agreement was signed, providing for the development of new collaborative activities in such areas as health planning and health economics, regional integration of health services, foods and drugs and biomedical research. The first major activity under this Agreement is a U.S.-Israel Symposium on Regionalization of Health Services, a priority concern of the Government of Israel.

In January 1981, the renewal Agreement (for an additional five years) for the U.S.-Egypt Program was signed by the Secretary and the Egyptian Minister of Health. Our program with Egypt continues to be active and effective in such areas as health manpower development, health services research, and studies of infectious and parasitic diseases, despite funding problems resulting from the phaseout of the Special Foreign Currency Program. Also in the Middle East, important efforts were made in 1980 to begin the development of relationships with Kuwait, Oman, and Saudi Arabia. Program development with these countries is expected to continue in 1981, subject to the availability of resources.

Following up on the signing, in June 1979, of the U.S.-People's Republic of China Protocol for Cooperation in Science and Technology of Medicine and Public Health, efforts were made in 1980 to develop plans of action for each of the ten areas agreed upon for initial cooperation. At the Second Joint Health Committee Meeting, held in Tienjin in November, plans for all areas were approved. Among the specific activities agreed upon were a program for testing hepatitis B vaccine in China; a major epidemiological study of cardiovascular disease in selected populations in China; and a descriptive study of health care and health services accomplishments in Shanghai County, followed by an analogous study in a country in the United States. Immediately preceeding the Joint Committee Meeting, a highly successful Scientific Symposium on Epidemiology was held.

The major new international health initiative undertaken by the Department in 1980 was an effort to establish relationships with countries in Sub-saharan Africa. In February 1980, the Secretary led a delegation of Departmental officials in visits to Nigeria and Liberia. In a related activity, Departmental officials participated in a visit, led by the President's Science Advisor, to Kenya, Senegal, Zimbabwe and Nigeria. Health leaders in each of these countries expressed considerable interest in cooperating in the health field with the United States.

In July, 1980, the Permanent Secretary of Nigeria's Federal Ministry of Health made a follow-up visit to the United States. During that visit, a general understanding was reached on areas for cooperation and to establish a U.S.-Nigeria Joint Task Force to develop collaborative activities in specific target areas, including food and drugs, nursing and paramedical education, health information systems, and communicable disease control. The Joint Task Force held its first meeting in February 1981, and agreement was reached on specific work plans and activities in several areas.

In August 1980, an Agreement for health cooperation was signed with Venezuela. The signing of this Agreement followed a visit to Venezuela, at the invitation of the Government, by a team of PHS experts to identify specific areas and mechanisms for cooperation. This Cooperative Program is expected to involve some reimbursement for services by the Venezuelans.

Progress continued on the U.S.-Mexico Border Health Initiative, a unique effort involving the Federal, State and local governments as well as private organizations of both countries, to improve health in the Border area. Cooperative activities include, among other things, improving the base of health data upon which to develop a more accurate profile of the health situation and major or potential problem areas.

The programs of cooperation with India, Italy, Japan, Poland, Yugoslavia, the U.S.S.R., among others, continued during the year.

The Department continued to participate effectively in the programs and activities of multilateral health organizations, notably the World Health Organization (WHO) and Pan American Health Organization (PAHO). These activities included active participation in the WHO process of strategy development to achieve the goal "Health for All by the Year 2000," development a U.S. position on the proposed International Code of Marketing of Breastmilk Substitutes, and a study of WHO's structure in light of its functions.

[CLERK'S NOTE.—The following is the administration's response to those questions in the record that were under review by the Secretary at the time the Department submitted earlier responses.]

HEALTH MAINTENANCE ORGANIZATIONS

Question: Should the Federal government, in your opinion, assume an increased responsibility to protect members of "failed plans?"

Answer: The present statute requires the HMO to demonstrate how it will protect itself and its members in the event of insolvency. Most small HMOs without adequate reserves buy "insolvency protection" from commercial insurance carriers. The problem with this type of coverage is that it goes into effect only after insolvency is declared. However, in most cases HMOs incur large debts prior to insolvency. These are not covered by the insolvency insurance. Nor are insurance carriers likely to make available insurance which would be effective before insolvency, since the degree of risk for the insurance company would be virtually incalculable.

Obviously, the best way to deal with this issue is with preventive measures, such as expanded technical assistance capability through management training and other approaches. Nevertheless, additional steps should be considered.

To date, there have been ten qualified HMOs which have failed. Although, in most cases, the termination of the affairs of these organizations has been orderly, the question of ultimate liability has been raised -- Are the HMO, the Federal government, or the providers ultimately responsible for paying the defunct HMO's debts?

The following policy options have been identified. They require further evaluation to determine feasibility of implementation.

1. Require all contracts between HMOs and providers (including hospitals) to contain provisions prohibiting the provider from billing the member for payment for services rendered (i.e., "hold-harmless provisions").
2. Create an "FDIC" type fund to protect those associated with failed HMOs.
3. Adopt an NAIC approach which would incorporate into state law statutory reserve requirements.
4. Permit the Department to exercise discretionary authority to use loan funds to assist those associated with failed HMOs (such as members, unaffiliated providers).
5. Allocate a portion of the operating loan to a contingency reserve to be used in the event of failure of the HMO.

Question: Should the current system of federal qualification be continued?

Answer: The federal system of qualification should be continued because it serves several important functions. First, federal qualification represents to both the consumers and employers (that are mandated by the dual choice provision of the Act) the government's guarantee that an HMO meets certain minimal standards such as a comprehensive health benefit package and the delivery of quality health care within a framework of a "fiscally sound" organization.

Second, federal qualification is recognized as a national standard. This identity is vitally important to large, multi-site national employers who often are dealing with as many as 20-30 different HMO's nationwide.

Third, qualification fosters competition in the health care industry through the dual-choice provision of the HMO Act. Employers are not required to offer a non-qualified HMO.

Fourth, a centralized, i.e., federal, qualification system is more efficient than a decentralized system. If qualification were delegated to the states, it would require a sizable increase in total resources than that required under the current federal system. Each state, in effect, would have to duplicate the capabilities of the Federal staff, i.e., specialists in marketing, finance, health service delivery, and management. Currently few states have this capability; thus many of the states would have to find the dollar and manpower resources to handle the qualification responsibility. In addition, the years of experience, simplifying the process, have led to a level of efficiency that might be difficult to achieve in some states. Over the past two years the process has been shortened from one year to 120 days and the application has been, and continues to be, streamlined.

Finally, federal qualification insures uniform application of the standards.

Question: What is the Department doing to eliminate disparities between federal and State HMO requirements?

Answer: The Office of Health Maintenance Organizations has taken a multi-faceted approach to eliminate disparities between Federal and State HMO requirements. First, the question of awareness of differences has been addressed by having an ongoing study to monitor the State laws that impact on HMO development. Very few Federal and State provisions actually conflict. A State's benefit package may not be as comprehensive as the federal requirements or a State may permit experience rating in some plans which must have community rate under federal law. However, to comply with both federal and State requirements, the HMO plan would be required to comply with the most stringent benefit requirements. If the State's law is more permissive - it allows the HMO to experience rate, rather than requiring it, there would be no violation of the State law if the HMO met federal requirements by community rating.

The Office of Health Maintenance Organizations has established an excellent working relationship with the States and shares a mutually supportive regulatory responsibility. There has been a mutual exchange of information between federal and State regulators in the health maintenance organization programs. There have been two national conferences held (and another scheduled for this Spring) for the purpose of developing more workable relationships between the State and federal regulators.

Annually, the Office of Health Maintenance Organizations program prepares a report for the governors of each State that describes the inconsistencies (if any) between State law and federal law in the establishment, development and operation of HMOs. The response from the offices of State governors, attorneys general and insurance commissioners has been favorable and the report has been used as a working document for many States to gauge the necessity for changes in their laws and regulations.

The Department has arranged for appropriate legal consultive assistance to be made available to the States for the purpose of developing their own HMO laws and regulations and this assistance has been accepted by almost all fifty States. There are now 39 States with specific HMO legislation and each year as the federal and State regulators meet, progress has been made in achieving consistency and avoiding disparity in State and federal regulatory requirements.

Question: Could the HMO movement be strengthened indirectly by lifting some of the Federal planning and eligibility restrictions that now inhibit its growth?

Answer: It is assumed that by "planning" restrictions reference is being made to the Health Planning and Resources

Development Act of 1974, as amended. The 1979 amendments to this statute went far in removing several barriers to HMO development. For example, the establishment of HMOs and the construction of HMO ambulatory care facilities were removed from certificate-of-need reviews. In addition, certain HMO inpatient facilities will no longer require certificate-of-need. Finally, HSAs may consider only the special needs and circumstances of HMOs in reviewing Federal funding applications from HMOs.

With regard to the present requirements imposed by the Federal HMO law on HMOs, it is unclear to what extent, if any, these requirements have inhibited HMO growth. Since the passage of the HMO Act in 1973, HMOs have proliferated in nearly all parts of the country and HMO enrollment increases at a national rate of about one percent a month.

Question: In terms of HMOs acting as a "restraining influence on rising medical costs," what consideration has been given to a Federal assistance formula characterized by higher proportional payments to those HMOs experiencing lower hospital costs and, conversely, a lower proportional share to high cost HMOs?

Answer: The HMO Act presently provides financial assistance for developmental activities, financing initial operating deficits and ambulatory care facility construction and equipment acquisition. The only funds presently available for operating expenses are in the form of loans and loan guarantees to assist HMOs to meet the amount by which their costs of operation during a period, not to exceed the first 60 months of their operation, exceed their revenue in that period.

It is assumed that HMOs can achieve savings through reduced hospitalization and other appropriate uses of health services. Such savings can be passed along to enrollees in the form of competitively priced premiums, new benefits, etc. It is assumed that no additional incentives for efficiency and effectiveness are needed. Therefore, no financial assistance to reward efficiency is contemplated.

Question: It is the Subcommittee's understanding that HMO legislation proposals accompanying the Carter budget include the elimination of the special annual 20% set-aside for rural HMO projects. It is further observed that the Carter budget reflects an anticipated $8.7 million carry over from the FY 1981 non-metropolitan set-aside balance. Does the Reagan Administration concur in these proposed policy changes?

Answer: The 20 percent rural set-aside and carryover are statutorily required by Sections 1303(i) and 1304(k) of the Public Health Service Act. Therefore, the Carter Administration budget reflected the mandated carryover from the FY 81 budget.

The Carter budget reflected the elimination of the 20 percent set-aside for FY 82, as does the Reagan budget.

Question: By reducing rural HMO projects, is the program not failing one of its primary objectives to increase the access to high quality care for all americans?

Answer: By eliminating the 20 percent non-metropolitan set-aside we are not proposing to reduce the number of rural HMO projects. The OHMO has not received an adequate number of fundable applications to expend all of the non-metropolitan set-aside funds in any year since the beginning of the program. The elimination of the 20 percent non-metropolitan set-aside reflects this fact and will provide the OHMO more flexibility in the expenditure of grant funds. It would still be our intention to fund any approvable grant applications from non-metropolitan areas within the limitations of our grant funds.

Question: In light of increasing support for metropolitan HMOs by private industry, why is the Department turning away from support of rural areas which are not being supported by the private sector?

Answer: The Department has no intention of turning away from supporting development of HMOs in rural areas. In the past we have funded every application from rural areas, which we felt indicated the potential for developing a viable HMO. We will continue to do so in the future within the limitations of our budget.

It is difficult, however, to develop a viable HMO in a rural area for the following reasons:

- Too few persons in the service area to support group/staff HMOs.
- The lack of large and medium-sized employers in the area to generate easy markets for the HMOs.
- The inability of the HMO to provide or arrange for the required benefits in cost-effective manner because specialty services are not readily accessable to the enrollees.
- HMO premiums are not competitive because the benefits which qualified HMO must offer are much more comprehensive than those offered by competing health insurers in rural areas.

The OHMO awarded a contract in late September, 1980, to study HMO development in rural areas. The contractor is charged with the responsibility of determining why some organizations have been successful in establishing HMOs in rural areas while others have failed. With this information we will better be able to assist grantees from rural areas in HMO development.

Question: Wouldn't it make more sense to recognize reality and convert the loan program into a grant program?

Answer: We do not agree that it would make sense to convert the loan program into a grant program. The Federal Government's role in the development of HMOs has been based on the proposition that HMOs are private businesses whose success or failure is largely dependent on the HMO's capabilities to effectively manage its own affairs. This requires the HMO to obtain self-sufficiency by earning sufficient revenues through membership sales to support all the costs of operating the health plan including the cost of borrowed capital such as the federal loan. We believe that the grant program is an effective incentive to encourage HMO development but should not be used to support operating costs. Operating costs should be supported only through loans encouraging the HMO to operate efficiently to minimize its cost of borrowed capital and maximize its capability of self-sufficiency for long-term financial viability.

BLOCK GRANTS

Question: Which of your programs are proposed for inclusion in the Block Grants to States?

Answer: Of the programs in the Office of the Assistant Secretary for Health only the Adolescent Health Services activity provides health services through grantees and is proposed for inclusion in the Block Grants.

Question: Specifically, are health education and adolescent health programs proposed for elimination, to be folded into a block grant program?

Answer: As noted above the Adolescent Health Services program is proposed for inclusion in the block grants to States. Also proposed for inclusion is the Health Education - Risk Reduction Grant program that is a component of the CDC. The Office of Health Promotion in the Office of the Assistant Secretary for Health coordinates health education activities with the CDC as well as with other agencies, but does not fund directly any health education grants.

PHYSICAL FITNESS AND SPORTS

Question: The physical fitness and sports program has requested a 36% increase in funding over Fiscal 1981. What new initiatives does the program anticipate in Fiscal 1982? What would be eliminated if the budget were held 10% below last year's budget?

Answer: Greater emphasis on coordination of sports medicine programs throughout the nation will be required of the PCPFS in FY 1982. The PCPFS will serve as the leader for the implementation of the exercise and physical fitness goals of the Surgeon General's objectives for the nation by 1990. This will require coordinating the efforts of 18 Federal Agencies that have responsibilities in this area.

If the budget were held 10% below last year it would necessitate the elimination of the PCPFS's regional clinics on physical fitness and sports which was targeted to provide leadership training for 6,000 professionals in the areas of physical fitness, recreation and sports.

Additionally, it would reduce our public information campaign by one-third and eliminate our radio and print ads which promote the importance of regular exercise and healthful living. This program is one of the main factors in the motivation for exercise participation among children and adults.

HEALTH CARE TECHNOLOGY

The National Center for Health Care Technology (NCHCT) has requested $4,412,000 for research activities in Fiscal Year 1982, a 65 percent increase over the Fiscal Year 1981 appropriation.

Question: What increased research activities are proposed for Fiscal Year 1982?

Answer: The question refers to the Carter Administration budget which was developed with regard to planned extramural research activities resulting from efforts started in FY 80. In June 1980 the NCHCT published a solicitation for research grants to assess the appropriate use of high priority technologies identified with the assistance of the National Council of Health Care Technology. These priority technologies included dental X-rays, cardiac nuclear imaging, computed axial tomography (CAT scanners), electronic fetal monitoring, and coronary artery bypass surgery. These technologies have a great deal of actual or potential economic and social impact and raise concerns about appropriate utilization from a viewpoint of effectiveness.

Question: Are these activities presently being performed by other components of the Department?

Answer: No. On March 1, 1981, applications to deal with these research issues were received from medical schools around the country, each requesting funds beginning in FY 82. Since there are no other programs in the Public Health Service with responsibility for such studies, the Division of Research Grants at the NIH has assigned them to the NCHCT for consideration. It is projects such as these which would have been funded by the budget requested by the previous Administration.

The medical schools submitting these applications include Yale, Albert Einstein, Harvard, University of Washington, New York Downstate, University of North Carolina, and the University of Connecticut.

CONSOLIDATION OF HEALTH EDUCATION PROGRAMS

Question: How much money could be saved if existing health education programs were consolidated?

Answer: Because health education is such an integral component of all of the Public Health Service programs, it would be impossible to consolidate all health education activities into a single unit. For example, the National Heart, Lung and Blood Institute (NHLBI) has a program mandate to provide information in response to public demand about high blood pressure, heart disease, and other problems related to the mission of the Institute. It would not only be counter to the statutory mandates, it would also be programmatically inefficient to prohibit the NHLBI from providing informational and educational materials to the public on high blood pressure and related matters. The same issues apply to programs such as Maternal and Child Health in HSA, Food and Nutrition in FDA, Immunization and Sexually-Transmissible Diseases in both NIH and CDC, and so forth.

Question: What savings would result from the States having to deal with only one Federal Bureau instead of numerous agencies?

Answer: This is a question which can only be answered through careful review of States own programmatic, accounting, and reporting processes. From the point of view of the Federal Government, most Federal agencies' health education efforts do not require extensive reporting by States. The bulk of these health education efforts are related to provision of informational materials and technical assistance by the individual agency with relevant program expertise. Hence, States might well find that to be relatively more inefficient to have to deal with a central agency which was one step removed from program expertise and operations. Though, theoretically a single site for health education activities would improve access to services and information, in fact practicalities would result in the reverse situation.

As an example, consider the information and education program for alcohol-related service programs, the various State agencies would go directly to their counterpart Federal agency for information on program content related to health education. In this way health education is handled more efficiently than by attempting to provide it through some relatively less informed third party.

Cross-cutting issues do require a coordinative mechanism and there are organizations within the PHS to handle such matters.

STATE INVOLVEMENT IN HEALTH EDUCATION

Question: If the States are given more discretion for deciding the exact array of health education programs, what emphasis do you expect would be placed on programs such as hypertension and family planning?

Answer: We can only assume that States would make their decision based on certain identifiable criteria. Example of such criteria would include: the prevalence of the problem at hand, the effectiveness of interventions to produce a desired change, and the existence of certain special target groups within a particular area. Based on such criteria, every State would make its own individual assessment of the problems within the boundaries. It is, of course, likely that programs such as high blood pressure and smoking would be among the high priorities for all States, but there are a number of others which might also fall into this category including accident prevention, family planning, alcohol and drug abuse control, physical fitness and exercise and stress control.

TRAVEL, TELECOMMUNICATIONS, AND STAFF UTILIZATION

Question: How much have you requested for travel expenses in Fiscal Year 1982?

Answer: The total travel requested for the Program Direction and Support Services activity in Fiscal Year 1982 is $220,000.

Question: What are your anticipated expenses in 1982 for publication and distribution of various materials?

Answer: It is anticipated that $190,000 will be required for printing and distribution of various materials in 1982. A major portion of the printing in the Program Direction and Support Services activity is for requirements in the Office of Management. Specifically, the requirements include the printing of grants, personnel, and financial management manuals; preliminary and final budget justifications; and non-standard forms. While printing costs have spiraled over the last year or two, this request represents only a five percent increase over the 1980 actual costs.

Question: What are the Office of Program Direction and Support Services initiatives for Fiscal Year 1982?

Answer: The staff offices of the Program Direction and Support Services activity will continue a number of initiatives in Fiscal Year 1982. These include preparation and planning for PHS responses to man-made or natural disasters; control of costs for voice telecommunications in PHS; and control of end-of-year procurement awards. As a result of the last initiative, in Fiscal Year 1980, PHS awarded only 21.6 percent of its procurement budget and 29.2 percent of its grant dollars in the last quarter.

HEALTH SERVICES RESEARCH: PRIORITIES

Over the past several years, many of the research activities of the National Center for Health Services Research (NCHSR) have been geared towards studying the effects of regulation on the cost of the health industry.

Question: How do you plan to redirect research activities towards determining the inflationary impact of eliminating health care regulations?

Answer: Among the categories of research subjects which NCHSR has supported are issues dealing with regulatory systems and procedures in the health care field. For example, studies have been funded on the effects of the Certificate-of-Need process of reviewing proposals for adding health facilities and services in a community. Studies have also been supported on the impact of the regulation of rates of reimbursement for health care services. For FY 1982 NCHSR will place greater emphasis in its grant development and review procedures on the role of competition in the health care market, thus identifying the influences of a non-regulatory approach. NCHSR is now preparing to develop a summary of research findings on competition in health care and a prospectus on potential research questions on this subject. We will actively solicit research proposals on these issues.

Question: In what areas will you be seeking new grant applications in Fiscal 1982, and how much funding will go to each area?

Answer: NCHSR plans to review the research grants which expect continuation funding in FY 1982 to determine the degree to which anticipated funding commitments are still valid and useful. In addition, NCHSR will assume some of the continuation funding in FY 1982 for research grants on technology issues initiated by the National Center for Health Care Technology. Therefore it is not possible at this time to determine with certainty the level of funds for new research which will be available in FY 1982. Based upon the best estimate that NCHSR may have about $1.5 million for new research awards or intramural studies in FY 1982, the priorities we expect to adhere to include: studies on the role of competition in the health care market, technology research, the influences which multi-institutional arrangements among health facilities have on costs and quality, developing more effective measures of health status, and the effects of changing State and local policies and programs on the health of the people.

Question: Are any existing activities scheduled for termination in FY 1983?

Answer: NCHSR reviews its priorities on a continuing basis, and will therefore consider the emphasis it will identify for FY 1983. Some current priorities will be dropped in favor of issues which take on more significance. Many specific grants will expire in 1983 as these studies are completed. The final award for a Health Services Research Center will be made in 1982, thus terminating the program during FY 1983.

Question: For both ongoing and scheduled new activities, please identify whether policy recommendations are to be targeted towards the consumer, the private provider, the Federal Government, or a combination of the three.

Answer: The research which NCHSR conducts and supports aims to provide information which can assist all of the groups identified. Obviously a specific study may be directed more to the concerns of providers or of consumers or of a government policymaker. For example, a study is under way designed to enable hospitals to link the separate computers which provide information on separate aspects of the hospital's operation, thus providing the administrator and the staff with an efficient capability for better communication and management. This study will be beneficial to providers. A second study is examining the differences in rates of death and disability from heart disease in rural communities which have different levels of intensity of emergency medical service response capability. The results will be of interest to State government program officials and policymakers.

HEALTH SERVICES RESEARCH

The budget narrative indicates that the National Center for Health Services Research is planning research on various national health insurance proposals.

Question: Now that national health insurance seems to be a dead issue, why is this type of research necessary?

Answer: The revised FY 1981 and FY 1982 budget narrative for NCHSR do not contemplate any specific research on national health insurance proposals. As noted in the testimory of Mrs. Hanft, NCHSR has completed the collection of extensive information on the health care services used by a sample of the U.S. population and on the ways in which this care is financed, including the extent of health insurance coverage. These data will be examined as a part of the on-going national health care expenditures study of NCHSR and will provide valuable information to policymakers on catastrophic illness and cost, interaction of providers and consumers in utilization of care, specific information on the Medicaid population, and use of services by types of illness. This information should prove valuable in consideration of a number of bills introduced on competition in health care.

HEALTH SERVICES RESEARCH: USER LIAISON PROGRAM

Question: Why are you planning to abolish the User Liaison Program rather than phase-down its present level of funding?

Answer: There is no plan to abolish the User Liaison Program of the National Center for Health Services Research. The legislation that governs the activities of the NCHSR requires that at least 5 percent of the amount appropriated for health services research, evaluation, and demonstration activities, or $1,000,000, whichever is less, be made available for dissemination activities directly undertaken by the NCHSR. The User Liaison Program is one element of the NCHSR broader program of dissemination, and it will continue to function. It will continue to provide substantive assistance through workshops and consultation to the non-Federal leadership of the health care system that is concerned with critical policy issues and operational problems.

With so many Federal programs now to be administered at the State and local level, it is increasingly important that the results of research be made available to policymakers at these levels of government. The User Liaison Program has shown to be an effective means of expanding our efforts in this area.

UTILIZATION OF HEALTH SERVICES RESEARCH

It is the responsiblity of the National Center for Health Services Research (NCHSR) to disseminate its findings in the public and private sectors.

Question: How does the Center intend to expedite response to its recommendations in the future?

Answer: NCHSR undertakes a dissemination program designed to bring to the attention of policymakers, program administrators, health care providers, and the public the results of its research. Often these findings enable these persons to take immediate action to put findings into effect. More rapid dissemination through publications has occurred in the last two years. Research syntheses are being prepared to pull together research results in specific program areas, like HMOs, for use by policymakers and the public. For example, NCHSR is completing a workbook which will enable hospital administrators who are contemplating the installation of a computer system to examine the variety of designs available in relation to his or her needs. Thus the work may be put to immediate use.

Question: What assurance do you have that the Department will implement your recommendations?

Answer: As a research agency, NCHSR does not make policy recommendations to the Department. Rather, we provide information which becomes one of the considerations in the Department's policymaking process. An example is the work of NCHSR on physician extenders use in rural areas and financing of graduate medical education.

COORDINATION OF VARIOUS STATISTICAL AGENCIES

Question: What efforts have you made to determine if savings are possible by combining your work with the statistical gathering efforts of such agencies as the Bureau of Labor Statistics, the Bureau of the Census, the Occupational Safety and Health Administration, and the Health Care Financing Administration?

Answer: A primary goal of the Public Health Service's data collection and processing plan is to insure that data collected by the various programs is done in a coordinated and efficient manner. It is the responsibility of the PHS Health Statistics Coordinating Committee, chaired by the Director of NCHS, to establish the methods and procedures by which this goal may be obtained and then to monitor the implementation of data collection and processing systems. The philosophy is that the resources and capabilities of one agency should not be duplicated by another when the data needs of both can be met through a single data system. It is the responsibility of the Health Data Advisory Committee, co-chaired by the Deputy Assistant Secretary for Health Research, Statistics, and Technology, to assure coordination across the Department. As a result of the philosophy and the functioning of the Coordinating Committees, we now have several projects underway, jointly financed by multiple agencies, designed to meet their data needs through a coordinated data collection mechanism. For example, the Health Care Financing Administration is providing funds to the National Center for Health Statistics to supplement the National Medical Care Utilization and Expenditure Survey in order to obtain detailed information on Medicare and Medicaid beneficiaries, thus providing HCFA with very useful program data at substantial savings; the NCHS contracts with the Bureau of the Census to interview survey respondents so that the expertise and resources of the Census field staff will not have to be duplicated; when producing the annual report submitted to the Congress on the health of the U.S. population, Health, U.S., the NCHS includes data provided by many Federal agencies including HCFA, VA, and the Bureau of Labor Statistics; the NCHS uses the expertise of the Center for Disease Control to process and analyze blood and urine samples drawn in the National Health and Nutrition Examination Survey; and the NCHS maintains a formal reimbursable work program through which other agencies can provide resources to NCHS to supplement existing large scale national surveys to obtain information needed for specific program purposes, thus negating the necessity of each of these programs to mount individual national survey mechanisms.

HEALTH STATISTICS

Question: In light of advocacy for increased competition and decreased government involvement among health care providers, what new initiatives, if any, are planned for Fiscal 1982?

Answer: The National Center for Health Statistics has no new initiatives proposed for Fiscal 1982. The Center's data systems provide general data on health services use, morbidity and mortality, disability and health status. Increased competition over time will be reflected in changes in patterns of use of care which can be tracked through national surveys such as Hospital Discharge and National Ambulatory Care Survey.

HEALTH STATISTICS

During the last year, the Center indicated that the Health Care Financing Administration was to assure a greater role in data collection activities.

Question: Are there plans to encourage other agencies to increase their responsibilitity in the data collection process?

Answer: The primary mission of the National Center for Health Statistics is to produce general purpose, national descriptive health data. Other agencies require additional data for the planning, management, and evaluation of their individual programs. The real issue is not which agencies are actually doing the data collection, but rather that the proper information is collected, assembled, and available without duplication of effort. To this end we have established two internal committees: the Health Data Advisory Committee and the Health Statistics Coordinating Committee. The former addresses issues related to integration of data collection among the various PHS agencies while the later coordinates activities between the PHS and other DHHS components.

SUBCOMMITTEE RECESS

Senator ABDNOR. The subcommitte will recess until Tuesday, February 24, when we will meet in this room at 10 a.m. to discuss appropriations requests for the Health Care and Financing Administration.

I do thank you for your time. We've run an hour and a half. I guess that's long enough for one sitting. Thank you all very much.

Mr. MILLER. Thank you.

[Whereupon, at 3:30 p.m., Monday, February 23, the subcommittee was recessed, to reconvene at 10:40, Tuesday, February 24.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

TUESDAY, FEBRUARY 24, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:40 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Harrison Schmitt (chairman) presiding.

Present: Senators Schmitt and Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF PAUL R. WILLGING, ACTING ADMINISTRATOR

ACCOMPANIED BY:

- TERA YOUNGER, ACTING DIRECTOR, BUREAU OF PROGRAM OPERATIONS
- ROBERT O'CONNOR, DIRECTOR, BUREAU OF PROGRAM POLICY
- ED KELLY, ACTING DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU
- MARTIN KAPPERT, DIRECTOR, BUREAU OF QUALITY CONTROL
- JAMES KAPLE, ACTING DIRECTOR, OFFICE OF RESEARCH, DEMONSTRATIONS AND STATISTICS
- DENNIS FISCHER, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT SERVICES
- ANTHONY ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The hearing will come to order, and I apologize for the delay. Leadership committee meetings have to be attended occasionally.

Today, we will hear testimony from the Health Care Financing Administration. This agency is responsible for administering the medicaid and medicare programs which pay for the health care services for the elderly and the indigent.

The overall budget for HCFA in fiscal year 1981 is $62.2 billion. This committee, however, does not appropriate for medicare, which is an entitlement paid out of trust funds.

In fiscal year 1981, the committee directly appropriated $26.9 billion to HCFA, certain payments to the medicare trust fund and for program management.

Here to testify before the subcommittee today is Dr. Paul Willging, the Acting Administrator of the Health Care Financing Administration.

We are glad to have you here, and we hope you will introduce your colleagues, and proceed with your overview presentation as we requested; and if necessary, any further remarks you would like to make, before we enter the question period.

Your entire statement, of course, will be included in the record.

INTRODUCTION OF ASSOCIATES

Dr. WILLGING. It is a pleasure to be here. I would like to introduce my colleagues at the table. Beginning on my far right, Mr. Tony Itteilag, Acting Deputy Assistant Secretary of the Budget in the Department; Mr. Edward Kelly, Acting Director of the Health Standards and Quality Bureau of the Health Care Financing Administration; Mr. Robert O'Connor, Director of the Bureau of Program Policy; Mr. Dennis Fischer, Director of our Office of Financial Management Services; Dr. James Kaple, Acting Director of the Office of Research, Demonstrations, and Statistics; Ms. Tera Younger, Acting Director of our Bureau of Program Operations; and Mr. Mark Kappert, Director of our Bureau of Quality Control.

PREPARED STATEMENT

I would like, if it's convenient with this committee, to insert my prepared remarks in the record.

Senator SCHMITT. They will be included.

[The statement follows:]

Statement of Paul R. Willging

My name is Paul Willging. I was formerly the Acting Director, Bureau of Program Operations, the Health Care Financing Administration (HCFA). I am now serving as Acting Administrator of the Agency. I am pleased to have the opportunity to appear before you today, and to give you an overview of HCFA as it is currently funded under the continuing resolution.

In FY 1981, HCFA is financing health care for 48 million aged, poor, blind, and disabled individuals. Our total estimated outlays are $56.5 billion for FY 1981, an increase of $7.4 billion, or 15.1 percent, over the FY 1980 program. This increase is due primarily to inflation in health care costs and increases in the number of beneficiaries whom we serve.

The current funding level for our appropriation accounts is as follows:

- $16.6 billion for Grants to States for Medicaid;
- $9.6 billion for Payments to the Health Care Trust Funds; and
- $1.0 billion for Program Management.

Grants to States for Medicaid

Medicaid is jointly funded by the Federal Government and the States. The current funding level for Medicaid of $16.6 billion reflects a $2.0 billion increase.

Efforts to effect improvements in the management of the Medicaid programs include:

- Refining our Medicaid Quality Control (MQC) System, with emphasis placed on its claims processing component.
- Examining all aspects of Medicaid financial management, and design of better linkages between grants, budgets, and cash management.
- Assuring that all States will have approved Medicaid Management Information Systems and that current operational systems are being used to their full potential.

PAYMENTS TO HEALTH CARE TRUST FUNDS

PAYMENTS ARE MADE EACH YEAR TO THE FEDERAL HOSPITAL INSURANCE (HI) TRUST FUND FROM GENERAL APPROPRIATIONS FOR THE FOLLOWING ITEMS PAID THROUGH, BUT NOT COVERED BY, THE TRUST FUND:

o HEALTH INSURANCE FOR THE UNINSURED - $659 MILLION;

o MILITARY SERVICE CREDITS - $141 MILLION; AND

o PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) ACTIVITIES FOR MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS - $40 MILLION.

A PAYMENT IS ALSO MADE ANNUALLY TO THE SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND WHICH, ALONG WITH MONTHLY PREMIUMS PAID BY ENROLLEES, FINANCES THE SMI PROGRAM. IN FY 1981 THE FEDERAL SHARE OF THE PROJECTED COST OF BENEFITS UNDER THE SMI PROGRAM IS $8.7 BILLION.

PROGRAM MANAGEMENT

THE FUNDING LEVEL FOR PROGRAM MANAGEMENT IS $123.9 MILLION IN APPROPRIATED FUNDS AND $886 MILLION TO BE TRANSFERRED FROM THE MEDICARE TRUST FUNDS. THIS REPRESENTS A 9.4 PERCENT INCREASE FROM THE FY 1980 COMPARATIVE FUNDING LEVEL. THIS ACCOUNT WILL PROVIDE FUNDING FOR THE FOLLOWING ACTIVITIES:

o PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS - $55 MILLION FOR DIRECT COSTS AND $118 MILLION FOR HOSPITAL REVIEWS FINANCED THROUGH THE FEDERAL HOSPITAL INSURANCE TRUST FUND.

o RESEARCH, DEMONSTRATIONS AND EVALUATIONS - $50 MILLION.

o MEDICARE CONTRACTORS - $694 MILLION.

o STATE CERTIFICATION - $34 MILLION.

o ADMINISTRATIVE COSTS - $176 MILLION.

REGULATORY BUDGET

THIS AGENCY IS RESPONSIBLE FOR THE USE OF FEDERAL FUNDS IN THE FINANCING OF HEALTH CARE SERVICES FOR BENEFICIARIES ELIGIBLE FOR MEDICARE AND MEDICAID. WE ISSUE AND ADMINISTER REGULATIONS TO ENSURE REASONABLE COST AND ADEQUATE QUALITY OF SERVICES FOR THE TWO PROGRAMS. OUR REGULATIONS, THEREFORE, AIM AT CONTAINING COSTS WHILE ENSURING ADEQUATE HEALTH CARE. THESE REGULATIONS DEAL WITH REIMBURSEMENT, ELIGIBILITY, SERVICES COVERED, CONDITIONS OF PARTICIPATION, AND GENERAL PROGRAM ADMINISTRATION. THEY

DIRECT ADMINISTRATION OF THE MEDICARE PROGRAM BY CONTRACTORS AND OF THE MEDICAID PROGRAM BY THE STATES.

ONLY A SMALL NUMBER OF HCFA PERSONNEL ARE DIRECTLY INVOLVED IN THE DEVELOPMENT AND PROMULGATION OF THESE REGULATIONS AS SHOWN BELOW:

	FTP	COSTS
DEVELOPMENT	91	$3,276,000
PROMULGATION	43	$1,548,000

THE REMAINDER OF HCFA'S APPROXIMATELY 5,000 PERSONS ARE INVOLVED IN NUMEROUS ENFORCEMENT AND MONITORING ACTIVITIES, ALL DIRECTED TOWARD ACHIEVING EFFECTIVE AND EFFICIENT PROGRAM OPERATIONS.

CONCLUSION

THE PROGRAM EFFORTS I HAVE DISCUSSED TODAY ARE DESIGNED WITH TWO OBJECTIVES IN MIND: TO BETTER SERVE OUR BENEFICIARIES; AND TO IMPROVE THE MANAGEMENT OF OUR RESOURCES. MR. CHAIRMAN, I WILL BE GLAD TO ANSWER ANY QUESTIONS YOU OR THE OTHER COMMITTEE MEMBERS MAY HAVE.

OVERALL CHART

HEALTH CARE FINANCING ADMINISTRATION
(dollars in millions)

	FY 1981
Medicare	
Part A Program	$27,261
Part B Program	12,329
Medicare Contract Administration	694
Medicaid	
Medical Assistance Payments	15,614
State Administration	867
HCFA Administration	327

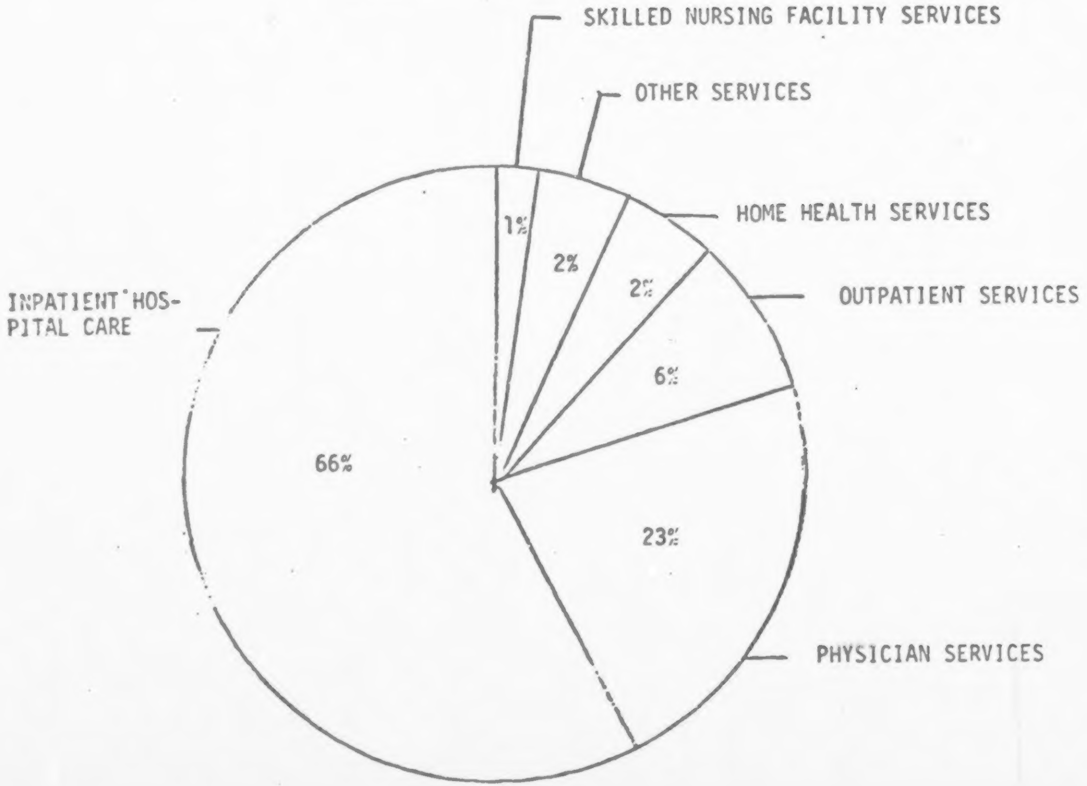
MEDICARE

BENEFITS

HOSPITAL INSURANCE Part "A"	SUPPLEMENTARY MEDICAL INSURANCE Part "B"
Inpatient hospital care (limited to 90 days per benefit period)	Physician services
Skilled nursing services (limited to 100 days per benefit period)	Outpatient hospital care
Home health services	Outpatient physical therapy and speech pathology services
	Home health services
	Other services and supplies

MEDICARE

BENEFIT EXPENDITURES



MEDICAID BENEFITS

Mandatory Services

Inpatient hospital services

Outpatient hospital services

Physician services

Laboratory and X-ray services

Skilled nursing facilities (for adults)

Home health care for those eligible
for skilled nursing facility

Early and periodic screening, diagnosis and
treatment services

Rural clinics

Family planning

Optional Services

Intermediate care facilities

Drugs

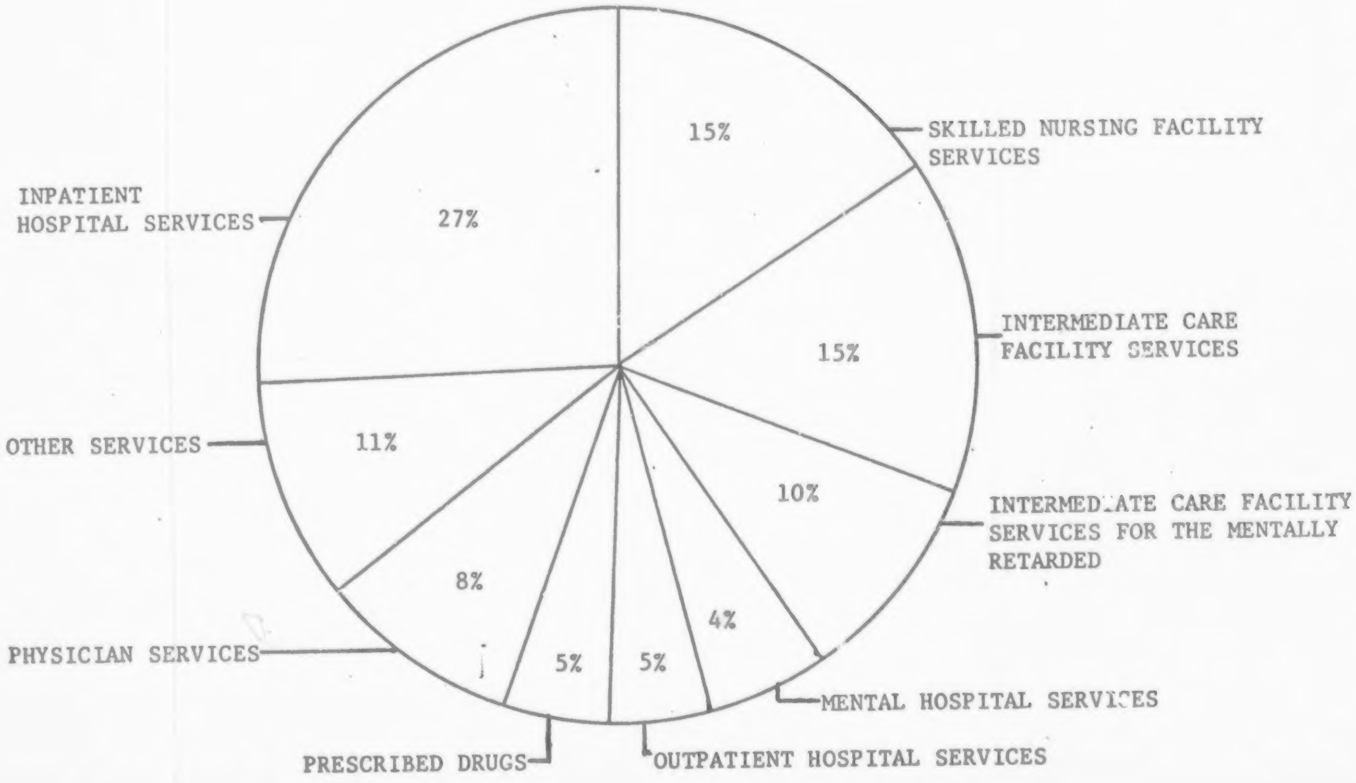
Dental

Clinics

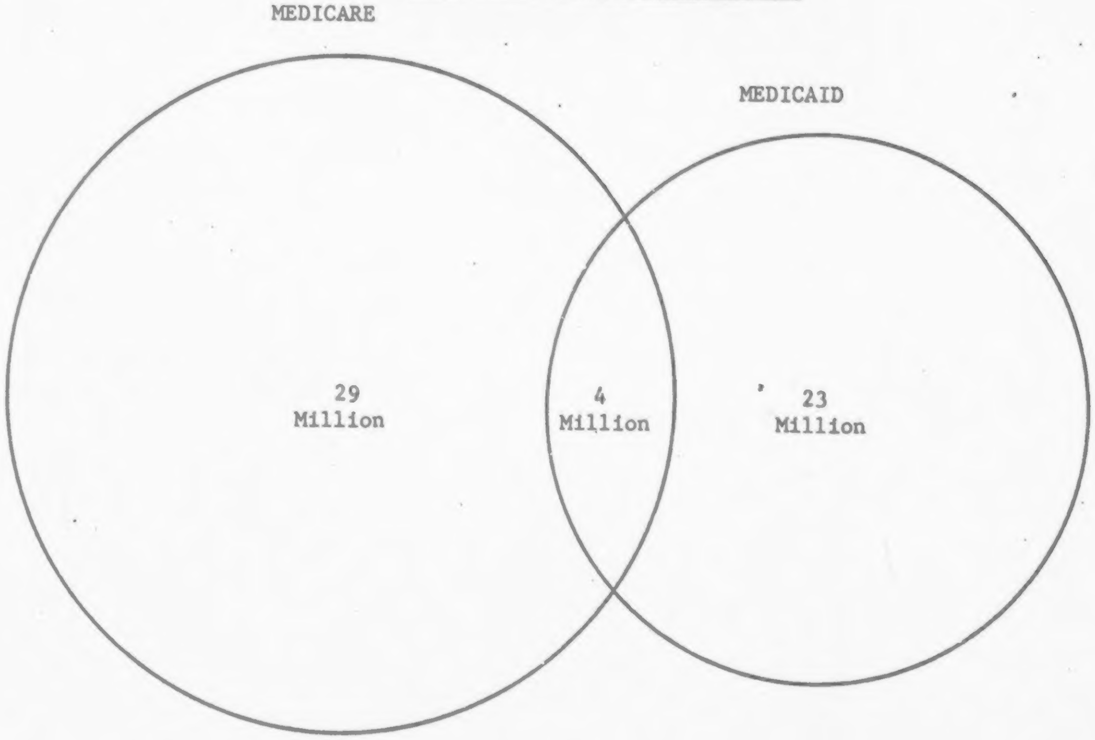
Other health care practitioners

MEDICAID

EXPENDITURES

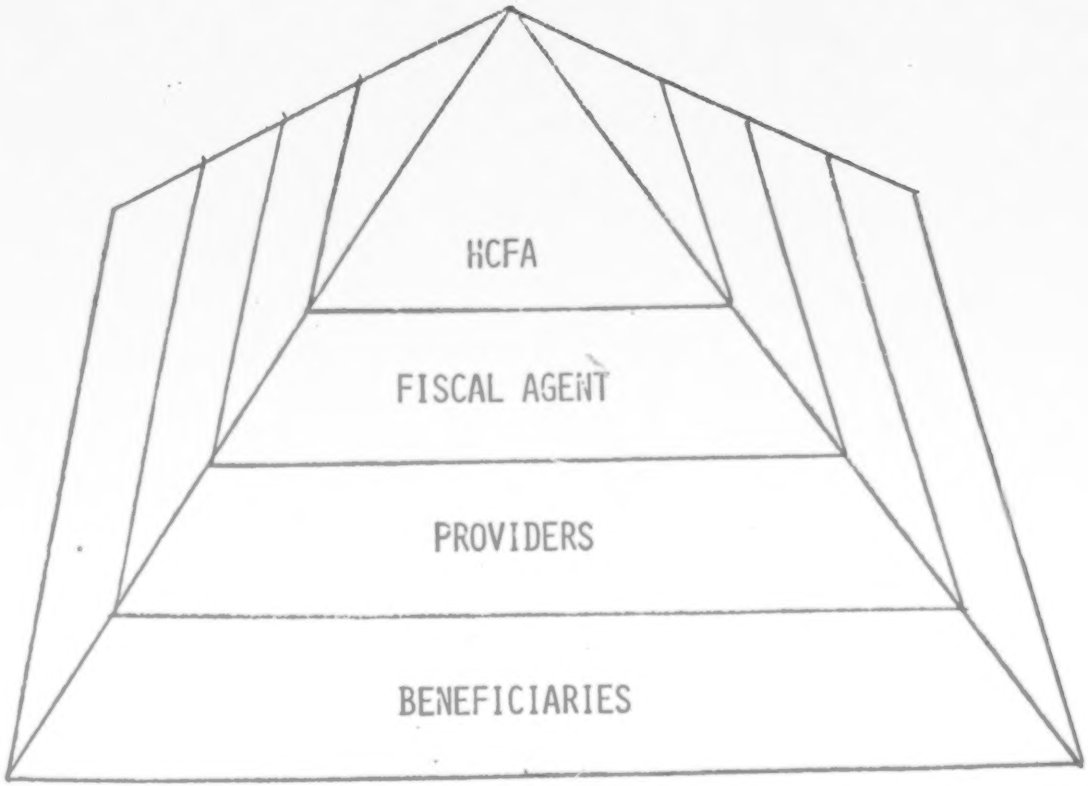


MEDICARE AND MEDICAID WILL BE SERVING ABOUT 48 MILLION PEOPLE IN 1981



1981

HCFA PYRAMID


HCFA
FISCAL AGENT
PROVIDERS
BENEFICIARIES

HCFA

PROGRAM ADMINISTRATION

FY 1980

Federal Government	HCFA	$182m	4,800
Fiscal Agents:			
o Medicaid	53	$765m	40,000
o Medicare - Part A	76	$222m	8,800
o Medicare - Part B	43	$414m	16,600
Providers			
o Hospitals	7,000	$45b in benefits	
Other Institutions	27,000		
o Physicians/Practitioners	375,000		

SOURCES OF FINANCING

	Principal Sources of Financing
Medicare Part A	Payroll Taxes/Investment Income, Federal Contribution
Medicare Part B	Enrollee Premiums/Federal Contribution
Medicaid	Federal Appropriation/State Matching Funds
Program Management	Appropriation/Transfers from Trust Funds

OVERVIEW OF HCFA

Dr. WILLGING. I will move on to a brief overview of the programs for which the Health Care Financing Administration is responsible: The attendant costs, the beneficiaries served, the benefits provided, and the manner in which programs are managed and reviewed.

HCFA is a young agency, established 4 years ago, as a part of a reorganization designed to bring together, in what was then the Department of Health, Education, and Welfare, the two major health care financing programs, medicare and medicaid; and the attendant quality control programs, the professional standards review organizations program, in particular, and the standard and certification activities.

HCFA's primary mission is to effectively oversee the expenditure of what today is approximately $55 billion in health care services, and to assure that the processing and payment of claims submitted by providers on behalf of the 48 million beneficiaries served by medicare and medicaid is carried out in the most efficient and effective manner possible.

HCFA'S FUNCTIONS

As we fulfill this mission, we have three basic functions performed by the agency.

The first of these is, on the basis of the statute and congressional intent, to interpret policies of who is eligible for the programs, the services for which payment can be made, and the levels of reimbursement to be paid for those services.

The second basic function is to maintain a set of relationships with over 100 contractors, the fiscal agents who manage the medicare program for us, and the 54 State agencies who are primarily responsible for the administration and management of the medicaid program.

The final function is to develop and apply sets of performance standards to assure that the State agencies and our fiscal agents for medicare are performing their activities in an efficient and effective manner.

HCFA'S PROGRAMS

Our first chart provides a very brief overview of the dollars related to the basic program, for which HCFA is responsible.

Medicare is divided into three basic parts. The part A program, which is primarily hospital benefits, accounts for approximately $27 billion in 1981. As indicated in your opening statement, Mr. Chairman, most of the part A program is funded through the trust fund, with a relatively small Federal contribution appropriated to cover certain groups and to finance PSRO activities for medicaid recipients.

The part B program, which is primarily physician services, accounts for about $12 billion in 1981. The part B program is funded through premiums paid by the beneficiaries, which account for about $3 billion in fiscal year 1981, and an appropriated Federal payment which makes up the difference of $9 billion in fiscal year 1981. The current premium is $9.60 a month.

Finally, there are expenditures for administration, those are the funds that are paid to about 100 contractors who process the bills for us. The contractors are for the most part commercial insurance companies and

Blue Cross-Blue Shield plans. This activity accounts for $694 million in fiscal year 1981.

The medicaid program has dual sources of funding. The Federal Government, through the appropriation process, accounts for over $16 billion in 1981, divided up between medical assistance payments, or payments made to the vendors, and State administration.

The States account for about 45 percent of the total cost. The Federal share of medicaid is the 55 percent.

HCFA administration is the third item on the summary chart. It contains funding for PSRO direct costs, research, State certification, and HCFA staff and attendant expenditures related to staff.

Just as a point of information, the costs of HCFA staff with attendant expenditures account for approximately one-half of 1 percent of the total program outlays for which this agency is responsible.

MEDICARE BENEFITS

Our second chart shows the benefits which medicare pays. As indicated, part A, the hospital insurance program, in addition to hospital care, includes skilled nursing services, and home health services.

The part B program or the supplementary medical insurance program is largely the physician service component of medicare, but it also includes outpatient hospital care, physical therapy and pathology services, home health services, and other services and supplies.

It is important to point out that medicare is very much an acute-care program. As you can see, the hospital benefit and the skilled nursing benefit are limited in terms of the number of days for which the program will pay. Hospital care is limited to 90 days per benefit period, that is per spell of illness. Skilled nursing services are limited to 100 days per benefit period.

MEDICARE EXPENDITURES

Medicare is not a chronic-care program. It does not have a long-term care component, as you will see on the next chart, which displays how medicare expenditures are distributed.

Inpatient hospital care accounts for 66 percent of the program. The next largest component of medicare expenditures is physician services, which makes up about 23 percent. It is important to note that about half of physician services are within the the hospital setting, such as surgery, pathology, and radiology services.

The essential point to bear in mind with respect to medicare is that we are talking about 75 cents on the dollar related to hospital services in an acute-care mode. This is especially important when we compare medicare to medicaid.

MEDICAID BENEFITS

Medicaid consists of mandatory and optional services.

The mandatory services are those which any State which wishes to participate in the medicaid program must provide. Currently all States, with the exception of Arizona participate in medicaid. States may alter the scope of mandatory services, but each service must be provided in some manner. Many of these services are analagous to those provided in medicare—in-patient hospital services, out-patient hospital service, and physician services.

Senator SCHMITT. Are there time limits on the benefit period?

Dr. WILLGING. States have the option of putting time limits. As more and more States suffer their own fiscal crises, there have been more serious limits placed on the inpatient hospital services. Some will have a limit in terms of the total number of days per year; others will have a limit in terms of the total number of days per admission.

What is interesting is that even though limits can be used, and are placed on some of the mandatory services, medicaid still is basically our long-term health care program, because unlike medicare it does not have statutorily imposed limits on skilled nursing care, intermediate care, or care for the mentally retarded.

States normally do not impose time limits on institutional long-term care services. This is one of the unfortunate areas of the program, once a beneficiary is in a nursing home, he may stay there for the rest of his life.

Later, I will talk about some of the problems that States experience with respect to the program.

It is in the area of optional service that States have a considerable amount of flexibility. They need not provide any of these services. Some of the major optional services include, intermediate-care facilities, drugs, dental services, clinics, and health care practitioners other than physicians.

MEDICAID EXPENDITURES

The fact that medicaid is very much a long-term health care program can be seen most dramatically in the next chart, which describes where the expenditures for medicaid are incurred—27 percent of these expenses are incurred in a hospital setting, 15 percent each in intermediate-care facilities and skilled nursing facilities, another 10 percent in intermediate-care facilities for the mentally retarded, and 4 percent in mental hospital services.

Thus medicaid is an institutionally based program. Some 75 cents of each dollar goes to institutional services. Unlike medicare, it is a long-term program, in that the skilled nursing services, intermediate-care services, and intermediate care for the mentally retarded, usually are for chronic-care patients. People who are going to spend an extended period of time in an institution.

MEDICARE AND MEDICAID BENEFICIARIES

HCFA's services are provided for some 48 million beneficiaries in 1981, medicare accounting for 29 million, medicaid accounting for 23 million.

Medicare serves the aged, the disabled, and individuals suffering from end-stage renal disease. Medicaid is available to those eligible for welfare, or for supplemental security income, the aged, the blind, the disabled.

About 4 million people are dually entitled to both program. They are primarily aged medicare beneficiaries, who because of their lack of financial resources, are eligible for medicaid as well.

PROGRAM MANAGEMENT

I would like to describe at this juncture how HCFA relates to the management of its program.

HCFA sits at the apex of a very large pyramid—not in terms of its importance, or its contribution, but in terms of its visibility. The Health Care Financing Administration does not directly manage its programs with the exception of our Office of Direct Reimbursement.

Largely, it manages medicaid in partnership with the States and medicare through its contractors. The next chart describes somewhat more graphically the relationship in terms of numbers between those various levels.

While the Health Care Financing Administration has a staff of about 4,800 employees, its fiscal agents and its partners at the State level have a much larger complement of staff, over 60,000 persons, who actually manage the programs on our behalf or in partnership with us.

I would also like to describe the relationship in terms of expenditures, I apologize that the accompanying figures represent 1980 not 1981 data, but the proportions are essentially the same. The Federal Government salaries and attendant administrative cost is approximately $182 million whereas a total of $1.4 billion go to, our contractual agents and our partners with respect to medicaid. Together we deal with over 400,000 providers, hospitals, other institutions, and physicians. We are responsible for paying out some $55 billion in benefits.

Once again, in terms of comparison, the total administrative costs for managing the medicare and medicaid program, not just the Federal salaries, but the total including the contractors' salaries and State costs, is approximately 3 percent—97 percent of the funds which flow through the Health Care Financing Administration, whether they are trust funds or appropriated funds, go for program benefit. Only 3 percent is used for administration of the program.

BUDGET FINANCING

The final chart describes the sources of financing. I alluded to this at the outset of my remarks. I'd like to go through it briefly again, because I know it is of interest to this committee. Medicare part A is financed essentially through payroll taxes, the FICA system, payments from States for their employees, and the investment income earned by the trust fund balance. The medicare part A program, $30 billion, is financed in this fashion, and about $800 million is contributed by the Federal Government.

For medicare part B, $3.6 billion is generated by enrollee premiums and interest on the investment of the trust fund balance, $8.7 billion results from the Federal payment.

The entire Federal share of medicaid is appropriated. The program management account which funds direct PSRO costs, State certification, research, medicare contractors, and HCFA administration is financed through an $893 million transfer from the trust funds and $128 million in appropriated moneys.

That concludes our brief overview of HCFA's programs and responsibilities. I and my colleagues would be happy to respond to any questions you may have.

HCFA STAFF RESPONSIBILITIES

Senator SCHMITT. Thank you, sir, that is a good review. And it doesn't seem overly complicated, but I notice that almost everybody somehow or another gets the two programs, care and aid, mixed up at some time or another.

Dr. WILLGING. My parents still don't know and I have worked in the programs for 6 years, Senator.

Senator SCHMITT. Could you provide us, for the record, a further breakdown of the types of duties that various categories of staff perform and numbers of staff involved in those various duties, some more detailed breakdown for the committee?

Dr. WILLGING. I would be happy to do that, sir.

[The information follows:]

HCFA Staff by Function

Function(s) Staff

Program Operations 615

- Provides direction and technical guidance for the nationwide administration of HCFA's health financing programs.
- Develops, negotiates, executes, and manages contracts with Medicare contractors and coordinates review of State plan amendments.
- Directs the establishment of standards for contractors and State agencies and evaluates their performance against these standards.

Program Policy 351

- Reviews existing policy, develops new policy and regulations concerning:
  - eligibility
  - coverage of benefits
  - utilization effectiveness of providers of service
  - reimbursement
  - limits to the costs of health care
  - other Medicaid and Medicare administrative and technical matters.

Quality Control 221

- Operates statistically-based quality control and penalty programs in the areas of:
  - Early and Periodic Screening Diagnosis and Treatment program
  - end-of-line bill review
  - eligibility review
  - third-party liability
  - Part A, Medicare
  - quality assurance
  - utilization control
- Reviews program expenditure information and selected providers to detect patterns of erroneous expenditures and assures that corrective action is taken by responsible HCFA components.
- Plans and conducts an internal HCFA audit program.

Support Services 815

- Provides direction for the nationwide operation of a centralized automatic data processing and telecommunications facility for HCFA.
- Provides reimbursement services to providers that choose to receive Medicare payments directly from HCFA.

Health Standards and Quality 285

- Develops, interprets, implements, and evaluates the health quality and safety standards for Medicaid and Medicare providers and suppliers.
- Monitors and validates the process for certifying these providers for participation in the Medicaid and Medicare programs.
- Develops, interprets, implements, and evaluates policies for professional standards review and, in support of the Office of Special Programs, for the End-Stage Renal Disease (ESRD) programs.

HCFA Staff by Function

Functions	Staff
Research, Demonstrations, and Statistics	367

- Provides leadership and direction for HCFA health care financing research, demonstrations, and statistical activities.
- Publishes HCFA research and program statistics.

Functions	Staff
Legislation and Policy	54

- Develops and evaluates recommendations concerning legislative proposals for changes in health care financing.
- Develops HCFA strategy for long-range and yearly policy plans in such areas as cost containment, reimbursement limitations, and alternative methods of reimbursement and coverage.

Functions	Staff
Management and Budget	307

- Develops and executes HCFA policy related to direction, coordination, and overall operational control of the HCFA:
  - budget
  - finance and accounting
  - personnel
  - management evaluation and analysis
  - administrative management services
  - project grants
  - contracting and procurement
  - work planning programs and operations

Functions	Staff
Staff Offices	245

- Assures the exchange of important information among the Administrator, HCFA components, and the Office of the Secretary, HHS.
- Directs efforts to evaluate HCFA regional operations and represents regional office concerns in central office.
- Provides leadership for HCFA in intergovernmental affairs.
- Maintains liaison with medical, dental, and allied health practitioners, institutional providers of health services, and academic institutions responsible for the education of health care professionals.
- Develops HCFA equal employment opportunity and voluntary civil rights compliance policy and assesses implementation of these policies.
- Plans, directs, and coordinates HCFA public affairs activities.

Functions	Staff
Office of Regional Administrator	84

- Provides executive leadership and guidance on behalf of the Administrator and Deputy Administrator at the regional operational level.
- Responsible for implementing national policy at the regional level.
- Participates in the formulation of new policy and recommends changes in existing national policy for all HCFA programs in the region.
- Serves as the principal HCFA contact with all professional organizations such as hospital and medical associations.

HCFA Staff by Function

Functions	Staff
Medicare - RO	579

- Represents HCFA at the regional level on all Medicare issues.
- Assures the operation of the Medicare program through day-to-day contact with Medicare contractors, providers, physicians, SSA regional and district offices, and others concerned with program operations.
- Conducts quality assurance programs and onsite performance appraisals.
- Negotiates and approves contractor budgets, changes to allotments, and final cost settlements.

Functions	Staff
Medicaid - RO	531

- Represents HCFA at the regional level on all Medicaid issues.
- Monitors Medicaid program activities and practices of State agencies through onsite management and financial reviews.
- Reviews State quarterly estimates of expenditures under the Medicaid program and recommends the amount to be incorporated in the quarterly grants.
- Issues orders suspending Federal financial participation on behalf of State payments to Title XIX providers and revocation of such suspension orders.

Functions	Staff
Program Integrity - RO	294

- Plans, oversees, and administers programs designed to prevent improper expenditures of funds through Medicare and Medicaid programs at the regional level.
- Determines the overall level of fraud and abuse in Medicare and Medicaid and pursues investigations of abuse and refers cases of criminal fraud to the IG.
- Participates in negotiating settlements to avoid court proceedings.
- Works with State Medicaid agencies and Medicare contractors to install and maintain systems for detecting and eliminating abuse.

Functions	Staff
Health Standards and Quality	490

- Represents HCFA at the regional level to assure that health care services provided under Medicaid and Medicare are furnished in the most economical manner.
- Exercises final authority for approval/denial/termination of all provider/supplier certification actions under the Medicare programs.
- Authorizes sample validation of accredited institutions to determine their compliance and comparibility with Federal standards.
- Conducts and authorizes investigations of complaints from the media, public, and Congress alleging deficient standards in provider facilities.

INSTITUTIONAL AND NONINSTITUTIONAL CARE

Senator SCHMITT. And as a general comment, that might help begin this discussion, I have heard it said that inherent in the two programs before us today is an incentive for institutionalized care rather than care that could be performed outside of a hospital or other type of institution.

How would you react to that?

Dr. WILLGING. I think that is largely a true statement, Senator. When the programs were first legislated some 16 years ago health care delivery was at a certain stage, and to some extent the programs were developed along that current understanding.

Institutional care was to a very considerable extent the type of care we were all readily familiar with in this country. As the years have gone on, I think we have found that there are other modalities of care which can be every bit as effective in providing for an individual beneficiary's health care needs and which, in some cases, are much more cost effective.

Unfortunately, in many respects, the programs, in terms of their legislative authority, have not necessarily caught up.

The medicaid statute, as an example, provided for a very institutional type of care—intermediate care facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded. The program does not recognize, in terms of its statutory authority, that there has now developed somewhat more effective approaches, including congregate living arrangements and other noninstitutional approaches.

We do have some benefits in our programs, such as home health benefits that are being used more. But as is shown by where the dollars go, it is still very biased.

TRENDS IN INSTITUTIONALIZATION

Senator SCHMITT. What are the trends? Have you been able to at least establish a downward trend in the institutionalization of the beneficiary?

Dr. WILLGING. Where there is somewhat greater flexibility, which is on the medicaid side, we have seen some States very innovatively begin to develop and apply alternatives which have dramatically reduced the proportion of their expenditures applied to the institutional setting.

Michigan has used a combination of personal care services, which are an optional service under medicaid, and has been much more able than some of the other States to move away from the institutional biases reflected in their expenditure pattern.

One of our goals at the Health Care Financing Administration is to learn from these experiences and work with other States to perhaps build that same flexibility in their program. So, we have seen some States succeed in this area.

Senator SCHMITT. Have you made any estimates of what the ultimate potential, let's say, over a 5-year period, of such a transfer of emphasis, a change of emphasis, would be in terms of reducing the cost or improving the efficiency of the delivery of services?

Dr. WILLGING. I am not personally aware of any. I would be happy to check on my return to the agency and provide it to you, Senator.

[The information follows:]

ALTERNATIVES TO INSTITUTIONAL CARE

Although many of our demonstration projects are exploring the cost-savings potential of alternatives to institutional care, it is too early to make a projection of the long-range cost impact of most of these approaches. Some of the alternatives under investigation include long-term care channeling agency demonstrations which seek to provide coordinated long-term care services in the community rather than in institutions, demonstrations of partial hospitalization and community-based mental health and alcoholism services, and home-based renal dialysis as an alternative to treatment in dialysis centers. One alternative that has been shown to have a program cost savings is ambulatory surgery. This successful demonstration has led to a change in medicare reimbursement that is estimated to result in a program savings of $32 million over a 5-year period. Home dialysis as an alternative to treatment in dialysis centers is also expected to lead to program savings in the long run.

HOME HEALTH SERVICES

Senator SCHMITT. Yes; if you have any information like that, we would appreciate it. But clearly, in the two pies on the chart that you told us about, your statement of the relative weight for institutionalization is very clearly illustrated.

Particularly in medicare, home health services are 2 percent of the total part of that pie. And I don't see any indication on the medicaid side of that kind of service unless it comes under other services.

Can you describe some of the medicaid activities, other than what you have mentioned for the State of Michigan, that would fit into a noninstitutionalized setting?

Dr. WILLGING. Home health services is included under other services. The optional services under medicaid do include some which can be used in a noninstitutional setting, such as personal care services. In fact some of the mandatory services, such as rural health clinics are noninstitutional types of services.

It bears recognition that for some of our population the institutional setting is, of course, the only appropriate setting, especially as one deals in medicaid with individuals who do not have a home in which they can be treated, and in medicare, with individuals who given age and debilitation can be helped only in an institutional setting.

I did not mean to imply that you would ever over time see a dramatic reversal within the program, but that certainly, on the margin, a fairly major impact can be made.

You will also see some impact on medicare, simply because of the emphasis on expenditures for institutional care, especially in part A. There is data available and I would like to provide it to you, which suggests that at least on the margin some fairly major impacts can be made by moving toward the noninstitutional setting.

One of the problems we have had in medicaid, and Michigan is an example, in one extreme is that there are States which have yet to, if not recognize, at least apply that recognition, that home health benefits, and personal care services can be used more aggressively to restructure their programs.

It is those States that are in the majority, which is why the total for home benefits under medicaid is still a very small number. On our chart, it is part of the other category, it is so small, not much more than 1 percent of the total expenditures of medicaid.

To some extent in medicaid the problem is that, what is one of the more appropriate approaches to dealing with the needs of people who would otherwise be institutionalized, cannot be paid for under any circumstances. It is not a home health benefit or a personal care service that is required. It is a different kind of living arrangement, sometimes called congregate housing, something between a pure home health benefit and an institutional service. But it is not currently authorized by the statute in the medicaid program.

POTENTIAL FOR CHANGE IN BIAS TOWARD INSTITUTIONALIZATION

Senator SCHMITT. Can you see any dramatic changes in the nature of the legislative instructions that you live with, in either program, medicare or medicaid, that would cause a dramatic shift in the percentage of institutionalized beneficiaries?

Dr. WILLGING. On the medicare side, I don't think I would see one which would cause a dramatic shift. On the medicaid side, my sense is that with the President's proposal to put a cap on medicaid and provide enhanced flexibility to the States, services may be provided in settings not currently authorized by the statute. One may see a fairly dramatic shift in the numbers of individuals who must be treated in an institutional setting.

Senator SCHMITT. What types of flexibility do you have in mind? Are you thinking of the requirements for full-time personnel of various categories?

Dr. WILLGING. I think some of the things that we have been talking about would deal primarily with different types of settings. Service would be geared to the specific needs of the individual, rather than geared to what is currently authorized as a benefit under the program.

If the individual could be adequately cared for in terms of his or her health care needs, in something less structured than an institution, but perhaps a little more structured than simply a personal care service, that State would then have the flexibility to move out to those kinds of alternatives.

Right now, they cannot do that and still get Federal financial participation.

Senator SCHMITT. So instead of what we now think of in terms of a skilled nursing facility, there might be a facility that would provide a different level of nursing care availability with maybe the skilled nursing or physician care on call rather than in place, that kind of thing?

Dr. WILLGING. It's one of the options I think the States might support.

Senator SCHMITT. Have you had any indication from the State providers regarding advocating this kind of change?

Dr. WILLGING. I can't speak to any specific provider groups as such. The people with whom we have talked with in the long-term care arena, professionals who have participated with us in the Health Care Financing Administration in discussing the needs of the elderly population, have certainly advocated recognition of the need for different kinds of arrangements in the delivery of long-term care.

There is some general consensus that the inflexibility of the program, in terms of the benefits in long-term care, does impede the most effective delivery of that care in those cases where something other than an institutional setting is the most appropriate.

LONG-TERM CARE DEMONSTRATIONS

Senator SCHMITT. It's my understanding that you have been conducting some experiments or demonstrations in long-term care alternatives. Do you have any information to report to us today on any conclusions from those studies or preliminary conclusions?

Dr. WILLGING. I don't think we have conclusions yet, and I will refer the question, if you don't mind, to Dr. Kaple, who is responsible for those demonstrations. But as a brief introductory comment, we have found that the needs of the elderly in terms of long-term care are by no means exclusively health needs in the traditional sense. They are social; they are economic; they are living. What we have facing us out in the real world is a variety of programs which deal with a specific piece of an individual's total needs in a compartmentalized manner.

It is sometimes very difficult to get the individual channeled to the right service setting to bring together the amalgam of services that the individual needs.

We have often compartmentalized those services, failing to recognize that the individual is not compartmentalized or bureaucratized. Trying to get the needs of the individual together in an effective and efficient fashion is one of our biggest problems.

Much of what we are now trying to do in terms of channeling demonstrations is designed to try to overcome those kinds of problems. I would like to refer to Dr. Kaple in terms of any specific conclusions we have at this stage.

Senator SCHMITT. Dr. Kaple.

Dr. KAPLE. We have no results from the new channeling demonstrations at this time. We have, however, mounted a series of demonstrations designed to address the very questions we are talking about here: What are the alternatives to institutional care? What is the most cost-effective way to pay for those services? What is the best way to manage those services?

These demonstrations are being carried out jointly with a number of States that have managed the medicaid program, and they will be carefully evaluated over the next 2 to 3 years.

Senator SCHMITT. How long have some of these demonstrations been in place?

Dr. KAPLE. This is the first year that the new channeling demonstrations have actually gone live in terms of providing alternate services or alternate casemanagement systems.

Senator SCHMITT. This fiscal year?

Dr. KAPLE. Yes.

Senator SCHMITT. When do you expect to have your first preliminary analysis of the program?

Dr. KAPLE. I believe the preliminary analyses are due in fiscal year 1983. The management of these demonstrations is being carried out jointly by the Administration on Aging, the Health Care Financing Administration, and the Office of the Assistant Secretary of Planning and Evaluation—ASPE—within the Department.

ASPE is the lead agency for evaluating this particular set of demonstrations. I believe their timetable calls for some results in fiscal year 1983.

Senator SCHMITT. We will recess temporarily while I handle a phone call here.

[A brief recess was taken.]

PROPOSED MEDICAID CAP

Senator SCHMITT. All right. The hearing will be in order.

Critics of the proposal to place a cap on medicaid payments have argued that artificially limiting health care payments for the poor will not reduce overall health care costs. Rather, this cap will transfer costs to States, counties, and cities and to the private sector.

What response, if any, would you have to this criticism?

Dr. WILLGING. Well, I don't think that necessarily need be the case. It's important to look at the cap in the context with which it has been presented by the President. It's essentially a quid pro quo arrangement.

Were we to impose a cap on the Federal expenditure for medicaid without in any way increasing the flexibility available to the States under the statute and regulations, to more efficiently manage their programs, and to be able to purchase services of adequate quality, in the most efficient fashion possible, then I think there may be some problem.

But the President has clearly indicated that there is a quid pro quo arrangement contemplated. The cap would be only a part of the total process. The other part would be the flexibility.

And quite clearly, in my own view, after a number of years of experience in the program, there are areas where the States, if given certain flexibility that they do not now have, could more efficiently direct those programs toward the provision of the best possible care, but more efficient care in terms of the sources from which they purchase it.

States have in the past attempted to do things which quite frankly have been prohibited, which would not have impeded the delivery of effective care, but would in fact have saved the States some funds.

An example, some years back, was when New York proposed to purchase laboratory services for its medicaid beneficiaries through a competitive bidding process that was not allowable given the statute. The State was enjoined by courts. The flexibility given to the States to take these types of actions would allow them to work toward a set amount provided by the Federal Government without necessarily having to redistribute the burden in terms of who pays for those services.

Senator SCHMITT. Has there been any analysis made of the relationship between potential beneficiaries and taxable income in the various States, to see what the total resources that might be available in States, relative to the need for health care resources?

Dr. WILLGING. In terms of the relationship between the Federal contributions to——

Senator SCHMITT. No; as an analysis of the effect of the cap. Obviously, some States have a greater taxable income base per beneficiary, potential beneficiary than do others.

What I am curious about is whether you have looked at the effect of a cap on a State-by-State basis?

Dr. WILLGING. It may have been, Senator, but I am not personally aware of that.

Senator SCHMITT. You have made no analysis in your agency as to distribution of beneficiaries on a State-by-State basis versus the overall resources available to the State to assume increased portions of their care?

Dr. WILLGING. No, sir.

Senator SCHMITT. Do you have any comment about whether that would be valuable in trying to analyze the effect of a cap?

Dr. WILLGING. I suspect it would provide some information that would be illustrative and enlightening as far as the discussion regarding the cap is concerned. We don't currently have plans to do that.

The proposal is of somewhat recent origins, as you are aware, and perhaps there is a great amount of analysis that will have to be accomplished before we are actually able to use that kind of proposal. That could be one of the pieces.

Senator SCHMITT. Do you know what approach the administration intends to take in their recommendations to the Congress dealing with the cap?

Will it be something they will try to do with both appropriations reduction and a separate authorization change to establish the quid pro quo or will it be done through the authorization mechanism first?

Dr. WILLGING. I can't speak to that, but I would like to refer to Mr. Itteilag, who perhaps can.

Mr. ITTEILAG. My understanding, Mr. Chairman, is that it will be handled through the legislative process only and that will not be proposed to the Appropriations Committee as a limitation.

Senator SCHMITT. You would not expect a reduction in the appropriations until the increased flexibility had been provided through legislative changes?

Mr. ITTEILAG. That is correct, sir.

FORMULA FOR MEDICAID CAP

Senator SCHMITT. Do you have any formula in mind by which the reduction, as a result of the cap or the effects of the cap, would be apportioned through the various States?

Mr. ITTEILAG. No, we don't, Senator.

Senator SCHMITT. There was an article in the paper this morning, apparently quoting some of the Governors that are in town, that a cap on medicare part A, hospital payments, might be appropriate, if it went along with the increased flexibility in their overall medicare/medicaid long-term care costs.

Do you think it's possible to single out a particular part of the program to provide the cap for?

Dr. WILLGING. Certainly, I think in most States, long-term care accounts for the bulk of the expenditures for services. I think there are legitimate grounds for applying that kind of cap on the medicaid program.

The States have raised an issue that certain kinds of services must be examined in relationship to medicare, medicaid, and other kinds of third-party payment systems.

If I recall the Secretary's comments at his meeting yesterday with the Governors, he indicated that there were some alternatives which he was prepared to analyze. Given that that discussion was only 24 hours ago, the analysis has not yet been undertaken.

There are issues obviously which I am sure we will want to look through as we propose to implement this kind of a process.

LIMITS ON MEDICARE INSTITUTIONAL BENEFITS

Senator SCHMITT. Do you have any information as to the proportion of medicare beneficiaries that utilized the full limit of the legal opportunity to stay institutionalized?

Dr. WILLGING. We can provide that, Senator.

My understanding is that on the hospital side, as an example, a very small proportion of medicare beneficiaries, around 1 or 2 percent, even approximate the total lifetime reserve of hospital days available to them.

Obviously, for that 1 or 2 percent, it is a very critical issue, but for the total beneficiary population, it is very small.

I don't have available at this moment similar data for the nursing home benefit, but I would be happy to provide it.

Senator SCHMITT. Could you provide us with some statistical background on the use of the various medicare opportunities that are provided?

Dr. WILLGING. We will do that, sir.

[The information follows:]

FULL USE OF MEDICARE BENEFITS

Information is available on the relative number of beneficiaries who have used the full extent of their medicare benefits for several types of medicare-covered services: Skilled nursing facility services, psychiatric hospital, and psychiatric outpatient benefits.

For skilled nursing facilities, there is a limit under medicare of 100 days of care per benefit period. The most recent data available, for 1976, suggest that for beneficiaries who received covered services in a skilled nursing facility—SNF—at least 8 percent of those stays in a SNF exhausted the beneficiary's SNF benefits. It is estimated that 21,710 SNF stays in 1976 involved exhaustion of full SNF benefits. There were estimated to be 274,000 SNF stays in 1976 by medicare beneficiaries in which at least 1 day of care was covered.

The lifetime limitation for medicare reimbursement for care in a psychiatric hospital is 190 days. In 1979 estimates were made of the number of beneficiaries who had used their entire lifetime benefits for inpatient psychiatric care. It was estimated that 4,609 beneficiaries had received the full inpatient psychiatric benefit of 190 days. That number would be 2 percent of the 246,625 beneficiaries who received any inpatient psychiatric benefits, or one-tenth of 1 percent of the 26,586,029 persons with medicare part A coverage.

Medicare outpatient psychiatric benefits are limited to $250 per year. In 1979, it was estimated that 18,446 beneficiaries had exhausted their maximum benefits. The number of beneficiaries who exhausted their outpatient psychiatric benefits was 7 percent of the 259,064 beneficiaries who received any outpatient benefits in 1979, or one-tenth of 1 percent of the 27,385,222 beneficiaries who were enrolled for medicare part B coverage.

MEDICAID ESTIMATING

Senator SCHMITT. Last year, HCFA changed its method for computing medicaid estimates. Instead of relying on a computer model that had serious flaws, HCFA decided to use the aggregate of all States as its budget request to Congress.

When this change was made, the committee was told that this new system would yield much more accurate estimates of overall costs.

The most recent estimate of fiscal year 1981 cost is up $704 million from the original estimate.

Would you care to explain this revised estimate?

Dr. WILLGING. Yes, sir; I would be happy to.

I think the historical approach taken by the Department in submitting medicaid estimates to the committees with respect to the annual budget is one which lent itself to a number of flaws.

As we look at a 10-year historical period and the accuracy of the Department's estimates for medicaid, we did find about 1½ years ago that we were off by an average of 5 percent.

That is, expenditures, when they finally were tallied, were an average of 5 percent off of the estimate that the administration had provided to the Congress.

Senator SCHMITT. Always on the high side?

Dr. WILLGING. No; as it turns out, sometimes high, sometimes low. We were not even consistent in our errors, as it turned out. What we found, looking at that same data, however, was that if we had relied on the State estimates, although individual States seemed also to vary, the aggregate was much closer. The difference between expenditures and estimates, historically, has been 2.5 percent.

Having recognized that, we did put in place a new set of forms as part of the attempt to primarily use State estimates. We are still not at the point where we can say we have either completed the process or have a totally successful methodology.

This year we are finding that primarily because of the problems entailed in implementing any major new process, we do not yet have the States or the Health Care Financing Administration totally in agreement as to how to fill out the new forms or the factors to be used in describing the estimates.

We are now working off of our third quarterly set of estimates since the fiscal year 1981 budget was first developed. Our anticipation is still, that when the process is completed, we will be able to at least meet or beat the 2.5-percent variance that the States traditionally have shown and at a minimum to do much better than the 5-percent variance that the Department has shown traditionally in terms of its estimates.

Senator SCHMITT. Would you expect the real dollar costs to go down with these new estimates on the average?

Dr. WILLGING. I would expect that we would be able to provide to the Congress a much more precise set of estimates so that if we come in and say the program is going to cost $16.6 billion in 1981, at the time we submit the 1981 budget, that the expenditures 1½ years later will actually be very close to $16.6 billion.

The problem that we had, in effect, made it difficult for Congress to know when it appropriated $16.6 billion that it was either going to be high or low. In either case, it presents Congress with some difficulties in possibly appropriating more than the program needs, in which case it hurts other programs, or less than it needs, in which case it faces large supplementals.

MEDICAID QUALITY CONTROL

Senator SCHMITT. What is your indication of error rates in the medicaid program?

Dr. WILLGING. While we have not finalized the reports, the error rates would appear to be very close to those published 3 or 4 months ago. The total erroneous payments, which combines third-party errors, claims processing errors, and eligibility errors, seem to be coming in at around the 5-percent level.

As best as we can judge, there is no statistical deviation. There are still a few analyses that have to be completed before we can certify to that finally, but it appears to be a pretty much stable level.

Senator SCHMITT. Do you think it can be reduced by any magic wand of some kind?

Dr. WILLGING. As one looks at the three components of the error rate, a couple of them are at the point where I am not sure any more reduction is possible.

For example, the error rate for claims processing, is under 1 percent. To some extent that relates to the embryonic nature of the monitoring process itself. It may go up or down as we have a more refined system. I don't think it will go up much past 1 percent and you can't reduce it much below that. For comparison purposes, medicare's processing error is about 2 percent and we take a lot of pride in that.

The biggest source of the errors is in the eligibility side, not the claims processing side. There the error rate is about 5 percent.

My feeling is that there is a potential reduction of a point or two off that. But there is a point where the administrative expense put in, begins to outweigh the savings in reduced erroneous payments. I hope that we can reduce eligibility error to a 3- to 4-percent level.

Our entire activity is geared to trying to move the rate down, concentrating on those States which have unacceptably high error rates. There are some that have rates above 10 percent. That is intolerable, in any sense, and we will continue to work with those States.

That, I would hope, would bring the national level down to 3 or 4 percent over the next few years.

AUTOMATED CLAIMS PAYMENT SYSTEMS

Senator SCHMITT. Is there any potential for an automated system of claim analysis and payment? Somebody suggested a medicare or medicaid credit card of some kind.

Dr. WILLGING. I am not familiar with the issue of a medicare/medicaid credit card. We do have in both programs a fairly sophisticated claims payment system.

On the medicaid side, we have a system called the medicaid management information system. It is a fairly powerful tool, not only in terms of processing claims, but in developing the information that stems from the claims processing system, telling managers what's happened to their program, where it's going, what the problems are, and developing variance analyses.

I may not totally understand your question in terms of the credit card approach——

Senator SCHMITT. That was an example of some kind of automated system utilizing a central data bank of information on eligibility.

Dr. WILLGING. On the eligibility side, we are moving into the area of trying to work with the States to automate their eligibility process.

Senator SCHMITT. Excuse me a second.

[Discussion off the record.]

Senator SCHMITT. Please go ahead.

Dr. WILLGING. The Congress passed legislation last year which provides 90 percent developmental funding for States to automate their AFDC eligibility systems. Thus States could utilize a computer for what has for a considerable extent been a manual program.

The benefits to medicaid will be inevitable because even though the legislation affects AFDC, medicaid eligibility is an offshoot of AFDC eligibility.

Senator SCHMITT. Have any States approved getting into this automated system?

Dr. WILLGING. The legislation was passed recently, but my understanding is that some States have already taken advantage of its provisions, the States of Wisconsin, Louisiana, and Michigan are the three that come to mind. I think that with the incentive that has been provided, we will see a move toward automation.

The Health Care Financing Administration will be working so that the medicaid and medicare eligibility will be tied together so we won't have separate eligibility for AFDC, food stamps, welfare, health care, or any of the other welfare programs in the States.

MEDICAID ERROR RATE VARIATION

Senator SCHMITT. Is there much variability between the States in error rates?

Dr. WILLGING. Dramatically; some are below 1 percent, some are as high as 15 to 18 percent.

Senator SCHMITT. Are there any systematic reasons why some States would be low and others high?

Dr. WILLGING. We have done a couple of analyses and there are one or two variables. Interestingly enough, and understandable, is the fact that the more resources the State appears to put into eligibility determination, the fewer errors it makes. I think it is very logical to assume that if you have an understaffed eligibility section in the caseworker component in the State, or if you are not paying adequate salaries to attract the right people, you will have a lot of mistakes. That is what we have found.

Mr. Kappert may be able to respond in terms of any other variables that we have seen, that indicate a higher eligibility error rate.

Mr. KAPPERT. I think the numbers that Dr. Willging referred to are essentially correct.

There is also a statistical problem in the sense that the higher numbers, in particular, are very much affected by small numbers of cases which represent very large expenditures.

So that even though the State could be very high as a result of one 6-month period of sampling, that number could also decrease dramatically in the next 6-month period just because of statistical sampling.

But the variability is still too great and there are, of course, some underlying management problems driving the error rates.

There is a lot of activity that we have underway in terms of going into the States, sharing the best practices, and giving them the technical support they need to cure various management problems. It is a very active process of working with the States using resources we have at the Federal and regional level.

We do believe, as was already suggested, that there is the potential to continue to drive the rates down.

Senator SCHMITT. Could we have, for our record, the State error rates by State and any trends that you are aware of in the individual States?

Dr. WILLGING. Yes.

[The information follows:]

Attached is the Medicaid Quality Control Executive Summary for April-September 1979 Report. The full report has been transmitted to the Committee.

EXECUTIVE SUMMARY

The attached tables and charts contain data on error findings produced by the Medicaid Quality Control (MQC) system for the April-September 1979 period and the July-December 1978 base period. The tables and charts reflect payment and case error data for eligibility, claims processing, and third party liability; a comparison of the April-September 1979 period and the July-December 1978 period payment error rates; and a listing of States which failed to meet error reduction targets.

The following summary highlights MQC findings for the April-September 1979 and July-December 1978 review periods. Precise definitions of MQC-related terminology are included in the Technical Notes.

- The national weighted average eligibility payment error rate (excluding cases where eligibility is determined under SSI) decreased from 6.2 percent in the July-December 1978 base period to 4.9 percent in the April-September 1979 period.
- Twenty-one States had eligibility payment error rates above the national weighted mean in the base period and were required to reduce these rates to the individual State targets by the April-September 1979 review period. Of these 21 States, 12 States met their error reduction targets and the data for one State is incomplete.
- Thirty-two States had eligibility payment error rates at or below the national weighted mean (6.2 percent) in the base period and were required to remain below this rate in the April-September 1979 period. Ten States rose above the national weighted mean in the April-September 1979 period.
- A total of 18 States are disallowance liable in the April-September 1979 period. All these States have experienced eligibility payment error rate increases from the base period.
- These 18 States must reduce their eligibility payment error rates to the individual State targets by the next review period, October 1979-March 1980, or be subject to another disallowance. Any State in which the eligibility payment error rate for the April-September 1979 period is below its target must remain below this rate or be subject to a disallowance.
- A new national standard will be established based on eligibility payment error rates achieved by States in the April-September 1979 period. This new standard will apply to the April-September 1980 period. Twenty-five States must reduce their April-September 1979 eligibility payment error rates to the individual State targets by the April-September 1980 period.
- The national weighted average eligibility payment error rate for all Medicaid cases decreased from 5.1 percent in the July-December 1978 base period to 4.3 percent in the April-September 1979 period.
- The national weighted average eligibility payment error rate for Medical Assistance Only cases is 5.2 percent; for AFDC, 2.3 percent; and for SSI, 2.1 percent.
- The national weighted average eligibility and liability understated case error rate is 6.5 percent for the July-December 1978 period and increased to 6.9 percent for the April-September 1979 period.
- The national weighted average gross third party liability payment error rate decreased from 0.5 percent in the July-December 1978 period to 0.3 percent in the April-September 1979 period, and the case error rate decreased from 0.8 percent to 0.7 percent.

- The national weighted average claims processing gross and unduplicated payment error rates for the April-September 1979 period are 0.5 percent.
- The deflated national claims processing payment error rate for July-December 1978 is 1.6 percent and the gross national payment error rate for April-September 1979 is 0.5 percent. Caution should be taken when comparing these rates due to the nature of the computations.[1]
- The total national weighted average gross payment error rate for the April-September 1979 period is 5.1 percent and the unduplicated rate is 5.0 percent.

The following summary highlights findings from the MQC error cause analysis tables for the July-September 1978 review period:

Eligibility

- Errors relating to beneficiary income account for the largest portion of case errors. However, errors in the area of resources (e.g., bank accounts, life insurance) represent a much greater percentage of dollars in error.
- The State agency is responsible for approximately two-thirds of all eligibility dollar errors in the Medical Assistance Only group, and the beneficiary is responsible for one-third.

Claims Processing

- Approximately one-half of total dollars in error are found in claims for the following services: Long term care; and "other" (e.g., laboratory tests, medical equipment and supplies).

Third Party Liability

- Over half of the dollars in error are associated with private health insurance; Medicare accounts for approximately one-fourth of the dollars in error.

A number of States have very low error rates in the areas of claims processing and third party liability. Future studies will focus on identifying factors which contribute to good claims processing and third party liability operating systems.

The Bureau of Quality Control is continuing efforts to improve the MQC system. Special studies have been undertaken to assess the effectiveness of the current third party liability (TPL) review process. Results of these studies have been analyzed and revised forms and instructions for conducting TPL reviews will be issued to be effective with the October 1980-March 1981 review period. These revisions will significantly improve the MQC review process' ability to detect errors.

Some jurisdictions were unable to complete reviews for one or both review periods. Footnotes on the attached tables and comments in the Technical Notes reflect actual status.

The following tables and charts reflect error rate findings for the July-December 1978 base period and the April-September 1979 period.

[1] The claims processing review procedures effective in the base period may have resulted in an overstatement of actual dollars misspent. HCFA has since revised the CP review methodology to more accurately reflect misspent dollars. These procedures were implemented in the April-September 1979 period. An approximation of the July-December 1978 gross claims processing payment error rate was produced based on a special study using the revised MQC procedures.

FRAUD REDUCTION

Senator SCHMITT. How many nationally? How many cases of medicaid fraud were brought to trial in fiscal 1980?

Mr. KAPPERT. Through the year 1980, the number of medicare and medicaid cases that were processed as a result of convictions was in the neighborhood of 200.

We approach these things at different levels depending on whether you are referring specifically to the medicaid program or the combination of medicaid and medicare program.

Senator SCHMITT. I said medicaid, but if you wish to combine them that will be fine.

Mr. KAPPERT. There are two types of cases that we approach. In one type there are convictions resulting from fraud. Our statistics, through the end of 1980, indicated that we had about 150 cases where we suspended from the program, physicians and suppliers, convicted of one type of crime or another.

On the other side, particularly in medicare, we have a process where we attempt to remove providers even without conviction. We have about 50 cases where we have been able to successfully exclude providers from participation.

Senator SCHMITT. Is there any appeal to such removal if it is nonjudicially imposed?

Mr. KAPPERT. Yes, there is; there are a series of administrative law judges throughout the country that are primarily responsible to the Social Security Administration and to social security cases, but we use them as well.

Most cases do go to that appeal level. The result normally is that we are upheld, but oftentimes, the length of the period for which the person is excluded is reduced.

Senator SCHMITT. Do you think that there is enough enforcement activity going on that, it acts as a deterrent to fraud?

Mr. KAPPERT. I think there is. We are also attempting to gear that up. For example, one way that we are doing that is with legislative and regulatory authority whereby the PSRO program joins in the effort and makes recommendations to us concerning exclusion of poor practicing providers.

DEMONSTRATION ON FRAUD REDUCTION

Dr. WILLGING. Senator, I think that my view of fraud is that it is still there and unfortunately is now becoming much more sophisticated. I think both programs, certainly Medicaid in the last few years, have been able to deal very effectively with blatant types of fraud—physicians submitting two bills for the same service—which sophisticated computers can now isolate.

What we are now concerned about and the FBI alluded to this in recent testimony are institutional types of fraud—kickbacks—which are much more difficult to detect.

We have undertaken, in concert with the State of New York over the last year or two, an analysis and a test of different kinds of mechanisms wherein one might be able to isolate this very sophisticated type of fraud, the kickback arrangements, and the like. I believe the final results are almost available and I will ask Dr. Kaple to speak to that.

We think this is where we will concentrate a lot of our energies over the next few years. Dr. Kaple, the New York study is almost done?

Dr. KAPLE. The particular demonstration you are referencing was with the special prosecutor in the State of New York. They developed some sophisticated methods for identifying fraud and abuse, particularly in provider settings, institutional or hospital settings.

There was at least a 2-for-1 payoff, as I recall, in the early results of that project. We would be glad to supply details for the record.

[The information follows:]

NEW YORK FRAUD AND ABUSE DEMONSTRATION

The New York fraud and abuse demonstration project with the New York Office of the Special Prosecutor has concluded its activities, but many of the fraud and abuse investigations initiated under this demonstration have not reached final legal disposition. Federal costs in the project totaled $7.5 million over 3 years. The project has already generated $4.4 million in recoveries of hospital payments. Potential recoveries of over $15 million are still pending. Thus, the total possible recoveries may approximate $20 million in return for a $7.5 million Federal investment.

The project also developed a detailed manual for the conduct of a fraud audit in a hospital and a second manual that spelled out investigative and prosecutorial techniques to be used in a hospital fraud investigation. These manuals form the basis for training courses conducted for other medicaid fraud control agencies around the country. There has been a tremendous demand for both the courses and the manuals developed under this project, which indicates that many States have found this to be a very promising approach.

FRAUD DETERRENCE

Senator SCHMITT. Please do; I don't have the exact testimony before me, but it was reported in the press that the FBI's criminal investigative division in testimony before the House made statements quoted here that people committing these frauds "have absolutely no fear of being caught." That sort of contradicts the testimony we just received in that you think your activities do act as a significant deterrent.

Mr. KAPPERT. Let me try to explain that. The kinds of activities the FBI was looking at are the kinds of things that can only be ferreted out by law enforcement agencies. Oftentimes undercover work is required. In the case of the FBI investigations, contacts with laboratories were made by agents posing as doctors.

Up to this point, we have considered that kind of work beyond our capability, particularly with the advent of the Inspector General's Office several years back. At that time, we were removed as an agency entirely from things that appear to be pure fraud, except as I explained before where there is someone convicted of fraud, in which case we move to remove them from the program so they no longer participate in it.

Senator SCHMITT. How does the Justice Department or the Inspector General get the information needed to make the decision that a case should be investigated and eventually prosecuted?

Mr. KAPPERT. We are very influential in finding leads. We have a number of programs where beneficiaries report to us cases of possible fraud, for example, if they suspect there are more services billed for than were rendered.

We do preliminary investigations where warranted and refer cases to criminal investigators. The kind of thing that the FBI was involved with in Labscam, as they called it, was more or less at their own initiative.

But there are many situations that we present to the Inspector General whose responsibility then is to seek prosecution, if the case bears that. We have an arrangement where if the case does not appear to have that potential, it is referred back to us and we try to use the other authorities that Congress has given us in terms of excluding without prosecution.

Dr. WILLGING. If I can speak briefly to this issue and what I think should be HCFA's role—I don't think it is an appropriate role for us to engage in undercover activity. There are other agencies of the Government responsible for that. What I do think is our role, a role for which we should provide more resources, is using the mechanisms for which we are responsible—the bill paying mechanism, the cost reporting mechanism—to develop the kinds of tools which would allow us, with the aid of sophisticated computer techniques, to find the variances which suggest at least the potential for fraud.

That is a legitimate role for us. And that was the purpose of the demonstration activity with Special Prosecutor Hines in New York. We are talking about a very sophisticated type of fraud. I think the FBI testimony indicated that as well.

I would not suggest that we do not have a role here, it is, however, a different role than the undercover agency.

EXTENT OF THE FRAUD PROBLEM

Senator SCHMITT. You would say today we are far from having control of this basic problem?

Dr. WILLGING. I would say we are not quite sure yet as to the extent of the problem. Clearly, we cannot slacken our efforts and rest on our laurels. The problem is given how varied the fraudulent activities are, it is hard to get a fix of how much fraud there is. I believe that as long as cases can be made as have been made, we have enough there to worry about.

Senator SCHMITT. Is the fraud invariably something perpetrated by the provider or is the beneficiary at times involved also?

Dr. WILLGING. Not invariably, once again, the precise definition is difficult. But in my sense of the medicaid program, fraud is more often than not provider fraud. This may not necessarily be true on, say, the AFDC side, but medicaid is primarily a vendor payment program.

No funds flow to beneficiaries of the medicaid program. I think the data we have from the activities we have undertaken over the years suggests the problem is largely a provider fraud problem.

A very small number of providers are involved, but a very small number can account for an awful lot of fraud.

Senator SCHMITT. Is that your feeling, that really the iceberg, so to speak, is made up of a relatively small number of providers?

Dr. WILLGING. That is my sense, Senator, and I have to admit it is intuitive, but I find cases that both amaze me and please me, where providers return money to the States, because they have been overpaid. It is an intuitive sense, but I think it is a correct one. I think it is a very small number of providers.

Senator SCHMITT. Do you know if the Justice Department shares this conclusion?

Dr. WILLGING. I do not know, sir.

FREEDOM OF CHOICE UNDER MEDICAID

Senator SCHMITT. Last year the Senate passed a provision in the reconciliation bill which would have allowed a State in its discretion to pick the providers that would receive medicaid payments. This provision became known as the Freedom Choice Amendment because it allegedly limited the range of health care choices available to medicaid beneficiaries.

Do you have any comment on the advantages or disadvantages of such a system?

Dr. WILLGING. I think the freedom-of-choice concept has to be reanalyzed. It is one of the possible areas of analysis which may be tied in to the President's proposal for capping the medicaid program.

Certainly freedom of choice, as it is currently applied on the basis of the statute, does not achieve its intended purpose. We, in effect, require of the States that freedom of choice prevail in terms of such services as laboratory services, when you and I, as private citizens, don't normally choose our own laboratory. To force the States to allow freedom of choice and not allow them to engage in competitive bidding for laboratory services, that is the kind of anomaly that has to be reanalyzed.

Some revisions in the freedom-of-choice provision with or without a cap are warranted. Certainly within the context of a cap on medicaid expenditures freedom of choice is one of the obvious areas for flexibility.

Senator SCHMITT. You, however, provide an option for selectivity on the part of the State; when you do that, are you not providing the potential for additional political or financial fraud?

Dr. WILLGING. I suspect any time funds are provided for a service, be it private or public, there is always potential for fraud. However, in some areas where States are allowed to be selective because the payment is not to a vendor in the traditional sense cost savings can be achieved.

For instance, States are allowed to buy things like eye glasses in bulk purchase. The State of Washington, I believe, is an example. We have, in effect, found some fairly dramatic cost savings and have not been apprised of any fraud or irregularity in terms of the purchasing processes engaged in by the States as a result.

I wouldn't deny, however, that there is always the potential when large sums of money get paid out for a service that something underhanded could take place.

Senator SCHMITT. But so long as there is some kind of a competitive bidding process, you would think that that potential would be minimized.

Dr. WILLGING. I am a great believer in letting the market tell you what the appropriate price is for the service and I think that should prevail in the health market as well.

ADMINISTRATIVE FEES FOR PRESCRIPTIONS

Senator SCHMITT. Senator Specter, do you have any questions?

Senator SPECTER. I do have one question which arises from a problem which has been found to exist in the State of Pennsylvania, and perhaps you are familiar with the problem.

It turns on a request by Pennsylvania officials to provide for an administrative fee of 25 cents to pharmacists who are part of the Pennsylvania program. And the reason that Pennsylvania has made this request is simply stated because of the administrative cost involved on the third-party payment. And a request was made by Pennsylvania, as I say, regional administrator, who denied the request—the appeal is currently pending before the acting administrator, and my question is: What is your view on allowing Pennsylvania that discretion, to include that kind of 25-cent administrative cost?

Dr. WILLGING. Coincidentally, Senator, I had a very enjoyable discussion yesterday with several of your constituents on that very issue. As I understand the issue, the providers, in this case, a number of chain pharmacies, have essentially no problem with our basic regulation which says that the medicaid program should not pay more for a service than the provider is charging to others.

But, in dealing with third-party payment programs of which medicaid is only one—paid prescriptions is another—additional allocations are entailed.

If you come in off the street cash and carry, it may cost the provider $10 to prepare a certain prescription. However, it may cost the provider $10.25 or $10.50 if he is dealing with medicaid, or paid prescriptions, because of claims forms, billing problems, and what have you.

I think where we left the discussion yesterday was that the point had been made effectively. It was an issue we had to deal with since we could not simply assume that what was good enough in terms of dealing with the cash-and-carry patient should be the same process we would take in dealing with the third-party payors. I did promise to personally involve myself in the issue and get back to the pharmacy representatives within the next week or two.

I do want to talk with the lawyers in the Department and with our policy staff, to see if there is a way of accommodating the essential principle of the regulation. That is, medicaid should not pay more than is normally charged by the pharmacist, but we still should account for the fact that it cost a little more money to deal with medicaid.

My sense is, and I am perhaps speaking prematurely, that we can accommodate those two positions together in a way that will preserve the integrity of our regulation but deal with the legitimate issue raised by the pharmacists.

Senator SCHMITT. What timeframe do you see for an answer to that question?

Dr. WILLGING. I promised 2 weeks and I will try to meet that.

Senator SCHMITT. What weight do you give to the recommendation of State authorities?

Dr. WILLGING. Most of my time is spent, Senator, trying to convince States not to drop reimbursement or drop benefits or drop eligibility.

I am very impressed when a State comes in and wants to provide a little more for their program. I am also familiar with the people who run the medicaid program in the State of Pennsylvania, Jerry Radke, and with the head of the agency, Ms. O'Bannon and they are a competent crew of people.

Senator SCHMITT. Do you know what the reasons were when the regional administrator denied their request?

Dr. WILLGING. I believe it was based on the reading of the regulation and perhaps the way it was described to the regional administrator, that a State simply applies something called an administrative fee on top of the normal dispensing fee and product cost.

My sense is that perhaps we dealt too much with the semantics of something called an administrative fee and not enough with other mechanisms wherein one might be able to achieve the same purpose, but using a somewhat different modality. An administrative fee, per se, based on a certain array of data might not be appropriate.

The discussions led us to a couple of areas where we might be able to serve essentially the same purpose without any kinds of violation of the regulations themselves.

REGULATORY FLEXIBILITY

Senator SCHMITT. Is this an example of the regulatory process which may be altered if block grants are given by the Federal Government to the States with administrative regulatory supervision left with the States, absent a Federal involvement?

Dr. WILLGING. It certainly could be an example, sir.

Senator SPECTER. What do you anticipate with respect to that kind of a change by President Reagan's administration for block grants and less regulation of the Federal Government?

Dr. WILLGING. In a broader framework, we do anticipate some change in the regulatory framework itself. I don't think we have gotten to the point of isolating specific changes in certain regulations.

There is, however, going to be that kind of flexibility. I think that has been indicated by the President to be a clear quid pro quo. The States are going to be expected to manage their programs against a set amount of funds from the Federal Government, and they do have to be given sufficient flexibility so as not to, in effect, incur costs simply because of the regulatory provisions in place.

What the specifics of that flexibility will be, I am not able to say at this stage, because I don't believe the discussion has moved that far in terms of conclusions within the Department.

Senator SPECTER. Thank you very much.

Thank you, Mr. Chairman.

MEDICAID COPAYMENTS

Senator SCHMITT. It's been suggested that medicaid beneficiaries should be required to pay a small fee for access to the medical services, a copayment fee.

How would such a system work? Do you understand what this suggestion is?

Dr. WILLGING. Yes, sir.

Actually, currently, States are allowed to apply copayments to certain services for certain categories of individuals. For example, copayments may, given the current statute and regulations, be applied on the optional services. For that reason copayments can be applied on drugs.

The problem some States have referenced has been the prohibition against applying copayments on mandatory services, for example, $2 for a physician visit.

There are arguments to be made on both sides of this issue and they have been made for a number of years now. On the one hand, studies show copayments will inhibit excessive utilization. One of the problems has always been, however, do you know whether it is inhibiting necessary utilization, as opposed to unnecessary utilization?

There have been some studies, such as the one I am familiar with that was done some years back in California, that showed while a copayment on physician services did reduce the use of physician services, in some cases, it was found to have increased the use of much more expensive services down the pike. The individual who would forgo a visit to the physician might end up in the hospital because he should not have forgone that visit.

Quite clearly, one can make arguments on both sides of the issue. I think one has to bear in mind the difference between a medicaid population and the rest of the country and that in some States we are talking about the poorest of the poor and even a $2 copayment can account for a fairly large amount of that individual's current disposable income.

But it is clearly an area of some controversy. I would be foolish in suggesting it isn't or that arguments can't be marshaled on both sides.

Right now, copayments on mandatory services are statutorily prohibited. The statute does require that the payment to the provider be considered payment in full as far as that service is concerned.

PREVENTIVE SERVICES UNDER MEDICAID

Senator SCHMITT. Do you think preventive medical care should be included as a reimbursable medicaid expense?

Dr. WILLGING. The early and periodic screening, diagnosis, and treatment—EPSDT—program is a required preventive service benefit for children. For adults, preventive care may be an optional service.

Senator SCHMITT. To what degree?

Dr. WILLGING. Once again, as one looks at the expenditure tables, preventive care for adults does not account for a great amount of expenditure.

I could provide for the record greater detail as to what States are doing what things in the area of prevention, how much money is going into it and what added advantage we seem to think we are getting out of that.

[The information follows:]

MEDICAID PREVENTIVE SERVICES

Data published in the 1979 edition of "Data on the Medicaid Program" indicate that optional preventive services of some type are offered by 20 of the 53 medicaid jurisdictions. These services are available only to the cash-assistance recipients in 4 of these 20 States. The remaining 16 jurisdictions offer these services to both cash-assistance recipients and to the medically needy.

EPSDT

Senator SCHMITT. We would like to have that. It just occurred to me that one option might be to have copayment for treatment services and no copayment for preventing services in order to maybe alleviate the criticism that you described.

I guess you were referring now to the California experiment.

Dr. WILLGING. That is certainly one option worth looking at.

Senator SCHMITT. In that regard, over the years, medicaid's early and periodic screening and diagnosis program has received considerable criticism for its failure to provide an effective system of preventive health care and treatment for medicaid children.

How do you coordinate this EPSDT? [Laughter.]

Is that the correct acronym?

Dr. WILLGING. I don't know; that is one I never used.

Senator SCHMITT. How do you coordinate those services with the ones provided under the mother and child health care program?

Dr. WILLGING. We try very hard to coordinate those services. I would like Mr. Kelly to speak to the specifics of that.

Program coordination in this area is one of the basic initiatives we have undertaken over the years. With respect to the EPSDT program—you know you are in the program when you have that run off your tongue.

Senator SCHMITT. EPSDT sort of rolls off the tongue. [Laughter.]

Dr. WILLGING. That will now be part of the vernacular.

Senator SCHMITT. Just don't stand too close to anyone.

Mr. KELLY. For the last several years, I have been working with the title V and the EPSDT programs, trying to insure that services are coordinated.

There now is a memorandum of agreement between the two programs. There had been some insistence upon a memorandum of agreement so that medicaid reimbursement can be received for children that are given EPSDT-type services under the title V program. The memorandum of agreement also assures that the services for the many grant programs under title V are made available in the areas where EPSDT-eligible children reside and that these children are able to be directed into those programs.

Senator SCHMITT. How many children do you estimate are eligible for EPSDT services?

Mr. KELLY. I believe approximately 11 million children are eligible——

Senator SCHMITT. You are not quite close enough to the microphone.

Mr. KELLY. About 9 to 11 million children are eligible, about 2 million are presently being served.

COVERING PREVENTIVE SERVICES

Senator SCHMITT. Do you have any other general thoughts about how preventive health care, preventive medicine, might be better integrated into the medicaid program to provide at least a longer term decrease in costs?

Dr. WILLGING. My view, Senator, has been that the program itself is not so much the impediment as is the understanding on the part of States and State legislatures and others of the power of the tool of preventive services.

It is a difficult task to convince State legislatures, who have to deal with the same fiscal constraints that we do at the Federal level, that an investment that will not necessarily bring its return today, is going to be very effective in terms of a return 4 or 5 years from now. Any legislature has the difficult task, as I am sure you have on this committee, of balancing off effectively the investment that shows no return this year, against the returns 3 or 4 years down the pike.

It is so very easy to let tomorrow take care of itself. I think we have to do a much better job in terms of marshaling the data to show the fact that there is a fairly credible return on some of those investments.

I don't think we have done as good a job as we can, in the Department, to show that.

There are data available to show the value of preventive services and we can do a better job of disseminating it. There are additional studies that perhaps should be launched to show the potential of preventive services.

Senator SCHMITT. Would you provide the committee with summaries of whatever you think would be appropriate in this type of deliberation?

As I hope is obvious, I personally have a very strong bias toward preventive health care and we ought to do everything we can to increase the opportunities, particularly in those areas where we already have essentially unequivocal information that a certain action now will prevent disease or injury later.

Dr. WILLGING. I would be happy to do that, Senator.

[The information follows:]

Research on the effectiveness of health prevention activities covers a wide range of procedures. HCFA is undertaking studies of several different prevention programs, particularly with respect to self-care, health education, and risk reduction approaches. The HCFA studies appear promising, but results of the studies are not available yet. There is evidence available, however, from studies supported by the Public Health Service and other sources that several preventive procedures are effective in preventing death or disease, as follows: Breast examinations and selected mammography for preventing and controlling breast cancer; hypertension screening for reducing mortality; pap smears for women under 65 for reducing cervical cancer; pneumococcal vaccine for preventing pneumonia among the elderly; digital rectal examinations and stool tests for occult blood for preventing rectal and colon cancer; and self-care—health education, risk assessment and risk reductions—approaches for preventing worsening of various chronic diseases such as asthma.

HEALTH MAINTENANCE ORGANIZATIONS

Senator SCHMITT. I presume you find it inconsistent that the Federal Government would both subsidize the growth of tobacco and subsidize the research and treatment of diseases caused by tobacco.

Dr. WILLGING. I would like to defer on that question, Senator. [Laughter.]

Senator SCHMITT. HCFA has done limited experiments in which medicaid beneficiaries are enrolled in health maintenance organizations. Have these experiments resulted in any reduction in medicaid costs, as far as you know, if so, how much?

If not, why not?

Dr. WILLGING. I am not personally familiar with the data; I will ask Dr. Kaple to speak to that. I will say I am a member of an HMO, and am committed to them, so my comments would be biased.

Dr. KAPLE. We have put in place, over the last 18 months, seven demonstrations involving incentives for medicare and medicaid beneficiaries to enroll in HMO's. At this time we do not have any experience with medicaid, but we do have experience with medicare. In those cases, where a medicare payment rate has been set, it has been set at approximately 95 percent of the adjusted average per capita cost. Within those costs, it has been possible on some occasions to expand services and in some cases, to do away with the coinsurance and deductibles for the medicare program.

So, there is some evidence that HMO's are cost-effective ways of delivering services. There is, however, a need for careful evaluation of these projects to determine that the enrollment procedures are not biasing the results.

There is a full-scale evaluation being launched and those results will be available in the coming 18 to 24 months.

Senator SCHMITT. Does any of the preliminary information indicate how successful, in these particular experiments, HMO associations have been in improving health care or reducing sickness?

There is supposed to be some preventive aspects to HMO?

Dr. KAPLE. That is the tougher side of the equation to determine—the actual impact on the beneficiary in terms of changes in health status.

The cost and utilization sides are relatively easy to measure. The actual long-term effects in terms of health status require a much longer period of observation and are much more difficult to quantify. They are, however, being addressed in the evaluation I mentioned in what might be considered a superficial manner, but in the only manner available now. That is, we simply ask the beneficiary how he feels his health status has been affected over the period of time in which he's been enrolled in the HMO.

The actual medical assessments of individuals who have been enrolled in HMO's would be extremely expensive and extremely difficult to carry out.

So, we have chosen to rely on somewhat less sophisticated tools. But we do know from the seven demonstrations I referenced that the HMO's are providing preventive services that are not normally part of the medicare benefit package, and we will examine the impact of HMO's on health status.

SECOND OPINIONS FOR SURGERY

Senator SCHMITT. With respect to second opinions, for surgery, do you have any information that confirms the positive reports in the Blue Cross-Blue Shield study?

Dr. WILLGING. Actually, the data on the demonstrations, a number of which we are funding, while very tentative and preliminary at this stage, do appear to be somewhat positive. I would ask once again, Dr. Kaple to deal with that issue. Within the Health Care Financing Administration, we clearly think, given the preliminary data, that it is a concept worth fostering.

In fact, we have changed the medicare payment policies over the last few years to make sure that at least people who wish a second opinion will have them paid for through the medicare program. In terms of specifics of the findings, Dr. Kaple?

.Dr. KAPLE. Yes, indeed; we have evidence now that the second opinion programs that have been put in place on a mandatory basis are cost effective.

We have demonstrated a decrease in surgery rates of approximately 20 percent, on the services for which second opinions have been required.

Senator SCHMITT. Which demonstrations were those? Would you identify them for us?

Dr. KAPLE. These were the demonstrations that took place in Massachusetts and Cornell—the New York Hospital mandatory second opinions program for union employees in the city of New York. The cost-benefit ratio for this program was 2.6 to 1 for every $1 invested, $2.60 was saved in terms of unneeded surgery or unconfirmed surgery requirements.

In the voluntary medicaid demonstrations that have been in place in Michigan and New York State, there has been a similar reduction in the rates of surgery. Approximately one-third of the cases referred for a second opinion resulted in nonconfirmation of the recommendation for surgery. There is lower utilization, however, in the Michigan program. Since it is voluntary in nature, only about 2 percent of the surgeries are actually referred for a second opinion.

Senator SCHMITT. Do you have any—are you doing followup to see if the second opinion was in fact the correct opinion?

Dr. KAPLE. Yes, indeed——

Senator SCHMITT. There is a 50–50 chance of being wrong. If the first one is wrong, you have a 50–50 chance of being wrong. [Laughter.]

Dr. KAPLE. There is in place a longitudinal evaluation that will address the specific question of the long-term effect in terms of cost/benefits and health status of the individuals, who have chosen to have or not to have a second opinion.

Dr. WILLGING. The reason I suggest that the data are tentative, Senator, is that if there are impacts from second opinion programs one aspect of that impact can be measured only after a number of years. That is, physicians and surgeons will come to realize that their opinion is going to be looked at by a colleague, by a peer, and this will influence their behavior. There may be over time less of an initial tendency to suggest surgery as the first opinion. That is one of the areas that must be analyzed to determine whether indeed there is a change in behavior. That sort of impact can be judged only after several years.

Senator SCHMITT. Has it ever been thought that—we will get to PSRO in a minute, the issue of surgery should be in some way referred to a peer review within this program?

Dr. WILLGING. I feel in a sense the second opinion is, indeed, peer review. One surgeon is passing judgment on the decision of a peer that surgery is required. To some extent, I consider that a form of peer review. It is not committee review as such, but it is certainly peer review.

FEDERAL PAYMENT FOR MEDICARE—PART B

Senator SCHMITT. The fiscal year 1982 budget request for supplementary insurance jumps $4.8 billion over the fiscal year 1981 appropriation, a 54-percent increase.

This account pays for the Federal share of medicaid part B payments, that is physician visits, beneficiary premiums pay for 23 percent of the costs of this program, the Federal appropriation for 77 percent.

Why does the cost of this program rise so rapidly?

Dr. WILLGING. I would like Mr. Fischer to respond to that, Senator.

Mr. FISCHER. Senator, the payments for the trust fund account is basically a financing account. We must deal with three major variables in making the estimate. First, we must determine the premium that the beneficiaries must pay. This is based on actuarial projections but is limited as far as its increase. As a result of the 1972 amendments to the Social Security Act, the premium is capped at the rate of increase of the cash benefit in the previous year. Second, we must take into account the projected part B outlays. Finally, we must make retroactive adjustments for any estimating error and must maintain an adequate contingency margin, as required by law. All of these factors cause the estimate to be a difficult one to make.

The 1982 request shows a significant jump over fiscal year 1981. The main reason was that at the end of 1979, the part B trust fund contingency, that is, its assets minus its liabilities, was estimated to be approximately 22 percent of the following year's estimated incurred expenditures. This was higher than our actuaries determined necessary, so the request for 1981, in terms of general revenues placed into the trust fund, was reduced.

Unfortunately, our estimates of the outlays for fiscal years 1980 and 1981 were a little bit low, and as a result, over the 2 years, there was a drop in the margins that the trust fund held. This resulted in the balance dropping below actuarially adequate levels, and required a larger request in fiscal year 1982 to restore a proper balance.

If you look at the rate of increase over the period of fiscal year 1978 through fiscal year 1982, the average increase is 23 percent, but there is a great deal of jumping back and forth between years.

Senator SCHMITT. Are you examining what can be done to smooth out those curves?

Mr. FISCHER. Yes, sir; we are working very closely with our actuaries. The data that we now receive on the medicare part B program has improved significantly; however, with the size and type of costs which comprise this account there are always estimating errors and estimating variances that creep in.

Also, we have to determine the premium and the actuarily adequate rate several months before the start of the fiscal year. As a consequence, we try to look out into the future, and sometimes those estimates are not quite as good as they could be.

Senator SCHMITT. Do you tend to be conservative or optimistic, let's say, about economic conditions?

Mr. FISCHER. Well, sir, we use the economic assumptions that are provided by the Office of Management and Budget in making our outlay estimates.

Senator SCHMITT. So you tend to be optimistic. [Laughter.]

PSRO IMPACT STUDIES

Thank you. That is a good answer. HCFA has estimated that the PSRO program has a benefit-cost ratio of 1.3 to 1. As an aside, in talking with people in New Mexico, I think they have estimated somewhat higher than that for that particular State.

This estimate is based on savings in the Federal medicare part A program, not savings in the total cost of running a hospital. Last year, a CBO report suggested that there is a fixed price for keeping a hospital open, and even if PSRO's does reduce medicare hospitalization, this merely shifts the cost of hospital care to the private sector.

How do you address yourself to the fact that this does not reduce the cost?

Dr. WILLGING. Two methodological approaches were taken in studying this issue. If the view is to be the total societal savings, the CBO analysis does bear a certain credibility.

If one looks at an analysis related only to the savings to the medicare program and the trust fund, one comes up with a different conclusion and, indeed, the two studies came up with two different conclusions based primarily on these different perspectives.

PHASEDOWN OF PSRO ACTIVITIES

Senator SCHMITT. Well, obviously, in the current economic climate, there would appear to be some advantage to reducing the Federal outlay and it would be very possible to shift the costs to where other alternative payment mechanisms exist. But, are you saying that, that is the only thing that PSRO does, at least with respect to Federal medicare part A?

Dr. WILLGING. PSRO's deal not only with health care delivery in the control of utilization, but also to the quality of care delivered through such functions as medical care evaluation studies—peer diagnosis and discussion.

I am thinking in terms of the question of a reduction of the Federal outlay for PSRO's that has already been proposed as part of the President's economic reform package. The administration proposed, that given the limited resources available in the budget, where PSRO's cannot be shown to recoup their investment, if you will, even with respect to medicare or the trust funds, they should be phased down.

The President's budget already published with respect to the PSRO's, does show a phasedown through 1983. This assumes that those PSRO's which will be retained through that period will be those which can be shown to be fairly cost effective as far as the program is concerned. This insures that we will not lose the benefit of the reductions that those more effective PSRO's have already shown in the terms of their impact on the trust fund.

As you indicated yourself, Senator, New Mexico would perhaps dispute the figures and they are right as far as New Mexico is concerned.

That is one of the phenomenons regarding the PSRO program—PSRO's vary in their degree of effectiveness. Some have been very successful, and some have been less so.

The President's proposal does provide that the successful ones be retained at least through 1983, until a competitive form of health care finance has been implemented with respect to the medicare-medicaid program.

CBO'S STUDY OF PSRO'S

Senator SCHMITT. Well, the preliminary budget statement that we have from the new administration contains the following statement, "Recent studies on the effects of the PSRO program by the Congressional Budget Office provides convincing evidence that the PSRO raises national health care spending."

Do you think the CBO has convincing evidence, if that's true?

Dr. WILLGING. I think given the methodology applied by the CBO, which is geared to the total budget, if you will—that is all health care delivery in the hospital sector, not just the medicare components—one would have to agree that the PSRO does not favor itself in terms of total cost because there are those fixed hospital costs which remain when PSRO's reduce Federal utilization.

What PSRO's do is to deny medicare reimbursement. To deny medicare reimbursement for a day of hospital care does not mean that no costs are incurred by the hospital. Even though medicare will not pay for these denied days, the total cost incurred still must be covered.

Senator SCHMITT. But the other side of that is what we were talking about earlier in a different context, is that the PSRO provides an incentive for a physician not to be denied payment and therefore to avoid unnecessary or unjustifiable costs. Is there any evidence that that, in fact, happens?

Dr. WILLGING. I think in some PSRO's that clearly does happen. Not all PSRO's are equally effective. In other words, I do not see necessarily an inconsistency between the data provided by the Health Care Financing Administration, which suggests a small cost-benefit return accounted for by only some of the PSRO's and the CBO study, which says that may be true but you still have fixed costs which are going to be absorbed by the health care financing system as a whole, across the board.

Senator SCHMITT. I don't think anybody is arguing that, but there are costs in addition to fixed costs which are under PSRO review?

Dr. WILLGING. To some extent those other costs for which medicare reimburses directly are saved. PSRO is effective in reducing the costs associated with a day of care when people who do not belong in the hospital are not admitted.

PSRO INCENTIVES

Senator SCHMITT. How do we save the PSRO's or develop incentives for all PSRO's to become good?

Dr. WILLGING. We'll be developing, in concert with the proposal enunciated by the President, a decision table wherein we'll be able to continue to fund, for a short time, the more effective PSRO's——

Senator SCHMITT. Only for the 3-year phase-out period?

Dr. WILLGING. It's assumed that at that point a competitive structure will be in place which would allow PSRO's to continue to exist as entities, but not simply as a tool of Federal regulation.

Those PSRO's which can prove their worth in the competitive marketplace as an adjunct or partner, if you will, in terms of their review decisions which limit the access and the use of health care, we assume would continue. But those PSRO's would be paid for and supported by their partners—insurance companies, labor, industry, and what have you.

In fact, Senator, there are PSRO's today which are tied in very closely to private industry and are serving as much the States, industry, insurance companies, and otherwise, as they are the Federal Government. This does not yet involve a dramatic amount of money, but it's moving upward every year.

Senator SCHMITT. I can be fully sympathetic with that. However, if the budget benefits in a cost-effective way, the Federal budget, the one we have to deal with, even though it's a redistribution of costs, do you not think that the Federal Government should invest its proportionate share in the PSRO system?

Dr. WILLGING. Our hope and our assumption is that we'll continue to garner that benefit by maintaining in place those PSRO's, at least through 1983, which have accounted for the bulk of that benefit.

PSRO's vary across the board in terms of the way they have contributed to reduction in utilization. There are those in effect which made a dramatic impact on utilization and some which have not made much of an impact at all. We'll retain our benefit by retaining those effective PSRO's until 1983.

The assumption is that by 1984, we'll have a different structure in place where PSRO's will not be necessary as a Federal regulatory arm. But I think this carefully constructed scenario, has to keep in place those PSRO's that do benefit the Federal Government in terms of a demonstrable reduction in lengths of stay and, therefore, a demonstrable reduction in expenditures that otherwise may have been incurred.

So, therefore, you will not see in the President's budget proposal a simple phasedown in terms of 1982 for the PSRO program. Were we to do that, you would be losing the benefits some of those have already provided.

ASSESSING IMPACT OF PSRO PHASEDOWN

Senator SCHMITT. Would there be a plan for evaluating the phasedown as has been posed to see if it should be stretched out or in fact some Federal contribution should continue where effective programs are in place?

Dr. WILLGING. Our data will show us whether there are impacts as we phase down the program and will enable us to assess our assumptions about benefits accruing from the PSRO program. We would want to look at the data and its relationship to our assumptions in terms of whether or not there should be a lengthier phasedown—whether or not a different approach should be taken, and the nature in which we would accomplish that phasedown.

Senator SCHMITT. Well, we can call it a phasedown, but there is still some pretty healthy cuts in fiscal year 1982.

The committee will try to gather, with your cooperation, more information in order to evaluate this proposal. You've got to be very careful in the context of trying to save money in the medicaid-medicare area that we don't eliminate one of the ways in which we've been reducing costs up until now.

Obviously, it's a variable from State to State and one thing we'll have to look at is how do we translate these good experiences to other States where the experience may not have been so good.

Dr. WILLGING. I think you're absolutely right, Senator.

FACTORS IN PSRO EFFECTIVENESS

Senator SCHMITT. Do you have the ability to accurately gage which PSRO's are truly effective, the various aspects of their activity?

Dr. WILLGING. I think we have some indices today. I would like Mr. Kelly to speak to that, but clearly our own analysis shows variability in performance and applying that variability to the decision we will be making regarding which will stay and which will go will test us analytically, but I think it can be done.

Mr. KELLY. We've assessed every PSRO against a certain set of standards and have already notified about 20 PSRO's that there was a great deal of work that needed to be done in order for them to meet the standards that other PSRO's are meeting. We used doctors and executive directors from some PSRO's in conjunction with Federal employees to do the assessing.

There have been several evaluations or assessments done on the national program, which include some cost-benefit analyses by individual PSRO's. That information will be used to determine the effectiveness of specific PSRO's.

Some PSRO's have private industry contracts and because of the flexibility that they can build into those contracts, have shown a greater savings in review of private industry. This aspect of performance will be considered also.

And finally, we will be looking at special activities some PSRO's are involved in, in contracts with States, such as review of ambulatory, pharmacy, and hospital outpatient departments.

IMPROVING PSRO'S

Senator SCHMITT. Do you have the authority to force PSRO, whose performance by your standards is inadeqate, to meet better standards?

Mr. KELLY. We have the authority through the funding mechanism, primarily, whereby we negotiate performance standards. We can also totally defund a PSRO or consolidate it with a different PSRO and this gives us considerable authority to encourage PSRO's to improve.

Senator SCHMITT. Have you discretion over whether they get funded each year or not?

Mr. KELLY. We have some discretion. We can terminate or reduce funding if there is sufficient cause, and we have done this in some cases.

Seven PSRO's that had been funded for a variety of time periods and then weren't aiming in the directions that the law intended, have been terminated.

Senator SCHMITT. It's been suggested by the California State Department of Health Services that PSRO's would be much more effective if they, "focused," on doctors and providers with high utilization rates and poor quality records, rather than looking primarily, as apparently most PSRO's do now, on specific patterns of diagnosis or procedure.

First of all, do you agree that that is the pattern today and if so, how do you respond to the idea of focusing on providers?

Mr. KELLY. I think we have been doing both things over the years. Before you can focus, you need to obtain information about the practice patterns of specific doctors and hospitals, as well as about the utilization characteristics of different diagnoses.

So there is a basic need to gather a general base of information. That is what was done in the first few years of the program. With that base of information about how providers act, you can focus on, for example, a doctor, a specific type of diagnosis in a particular hospital, or an entire hospital.

As of now, we are focusing a great deal of the concurrent review that we used to do. We only review concurrently about 40 percent of cases; the remainder are monitored retrospectively. We still have to collect data on all Federal patients, so that we can adjust review activities as the data indicates the need for such modifications.

THE CERTIFICATION PROCESS

Senator SCHMITT. With respect to certification of long-term care facilities, what steps can you take to increase its review of long-term care facilities and make sure that the elderly, particularly, receive high-quality care?

Mr. KELLY. The survey and certification system for the medicare/medicaid program has been the focus of various hearings on some of the conditions that are used in the long-term care certification processes and we have held hearings on the process of surveying that we have used for the last 10 or 15 years.

At those hearings recommendations were made—proposing either a change in the frequency of surveys or the intensity with which we survey. If such changes were adopted, and we expect they will be, there should be some cost savings for both the Federal Government and the providers. We believe that the annual surveys that have been done for last 10 to 15 years have shown us that there are providers who continuously do an adequate job. It may be that they should be visited only once every 2 years or even less often than that.

And, there are some providers that need constant attention to insure that they achieve and maintain the standards set by HCFA.

These are the types of changes wil will be making in the survey process. The Administration will also request of the Congress a change in the requirement for frequency of SNF surveys, from annual surveys to something less often than that for good providers.

Senator SCHMITT. What kind of survey?

Mr. KELLY. Skilled nursing facility.

Senator SCHMITT. SNF? [Laughter.]

Mr. KELLY. I didn't invent it, I just use it.

Senator SCHMITT. One of Schmitt's laws in the unique natural environment of Washington is that agencies and programs quickly take on the characteristics of their acronyms. [Laughter.]

THE SWING-BED APPROACH

So you have to be very careful.

In New Mexico, it has appeared over the years that there could be a great deal more availability in long-term health care facilities, if as we were talking earlier, there were more flexibility in tailoring the care facility to the true need of the beneficiary. Also, if we adopted more flexibility in the swing-bed concepts.

Would you care to comment on either one or both?

Mr. KELLY. I think somebody else should comment on swing beds.

Dr. WILLGING. Certainly, the concept of flexibility is one which has been a thread through the discussion, Senator. I think it's an area where the States are generally right. As we previously discussed, States are somewhat limited to dealing only with required benefit packages—the kinds of benefits described only in the statute.

Those are not necessarily the benefits an individual may need in terms of his or her basic health care requirements. In terms of the use of swing beds as a concept designed to increase the availability of certain kinds of long-term care services, there have been problems in the past in terms of reimbursement, certification. Especially where we are talking about patients who begin in a hospital setting, are seen to no longer require that care, and then move down into another level of care.

I would like Dr. Kaple to respond to the undertaking we have already seen in the Health Care Financing Administration to deal with that issue and where we stand to date.

Senator SCHMITT. Before Dr. Kaple responds, let me suggest that you continue to look at long-term care flexibility in the context of many rural situations where literally a fully qualified long-term care facility in a small community just literally is not possible.

You cannot retain the help, you cannot find the financing to build a kind of facility that the standards seem to require. And so what is the net result? You have not helped anybody. And you have no care facility for those that need it.

So clearly, flexibility has to be built into those kind of situations and I think almost every community in my State, of any significant size, could have long-term care facilities very, very quickly provided, within the private sector, if some flexibility, significant flexibility was built into the rules and standards.

So I certainly hope that we can see that happen fairly quickly.

Dr. WILLGING. In terms of that, your specific question, before we go to the research we have done. I would like Mr. O'Connor to speak to that.

Mr. O'CONNOR. There is a provision in the omnibus reconciliation bill passed by Congress to allow swing beds in rural areas where the hospital has less than 50 beds.

Mr. KELLY. In addition to that, I believe from what is going on in many other Western States, you are talking about some of the traditional requirements within our conditions of participation, and those are the ones we will be proposing to make more flexible. I believe we will have specific changes either this fiscal year or early next.

Dr. KAPLE. Over the last 3 or 4 years we have had some demonstrations with the swing-bed concept in several States, including Iowa, Utah, South Dakota, and Texas.

The results of those demonstrations are in, and in fact, are the basis upon which the reconciliation bill changes which Mr. O'Connor mentioned were predicated.

The demonstrations showed that if an acute care bed can be utilized for long-term care in rural communities, it's cheaper to provide that care in the swing bed than to invest in the capital needed to develop new nursing home beds.

The results were limited to rural communities, under 50 beds, in terms of what was included in the reconciliation bill. We do have on the drawing board plans to test the same concept in urban areas. We will be looking at this in future years.

Senator SCHMITT. Is it your feeling that 50 beds was a reasonable cutoff?

Dr. KAPLE. Well, the demonstrations included both hospitals over and under 50 beds. The results were clear that it was cost effective either way. The Congress in the course of determining the exact language of the bill chose 50 beds.

Senator SCHMITT. Do you know for what reason?

Dr. KAPLE. No; I was not there at the discussion.

SUBMITTED QUESTIONS

Senator SCHMITT. Gentlemen and lady, it's been very informative to have you with us. We will have additional questions for the record and we will continue to pursue this subject as soon as we have more details on the Presidential proposal.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

ALTERNATIVES TO FEDERAL CAP

Question: In a Budget Issue Memoranda dated February 1981, the CBO has suggested the elimination of the 50% minimum Federal matching share for the Medicaid program. This would have the effect of focusing the cuts on those states with the highest per capita income relative to the national average. According to CBO, this approach is more likely to reduce the amount of variation in benefits and eligibility among the states compared to an across-the-board cap on the Federal share. CBO estimates this would reduce the Federal share in only 16 States, while saving $700 million in fiscal year 1982 and as much as $1.8 billion by fiscal year 1986. What comments do you have about this alternative approach?

Answer: Even if the Administration's goal in imposing Medicaid budgetary restraint were simply to reduce the amount of interstate variation in benefits and eligibility among States, the effect of eliminating the 50% minimum Federal matching share for the Medicaid program is unclear.

In fiscal year 1982, twelve States and the District of Columbia would receive lower Federal matching if the minimum percentage were eliminated. Those affected would be: Alaska, California, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Michigan, Nevada, New Jersey, Washington, and Wyoming.

As the CBO Memorandum points out, several of the high per capita income States receiving the minimum 50% Federal match now provide broad eligibility and many optional Medicaid services, which they could choose to trim in response to reduced Federal program support. High state per capita income, however, has not necessarily translated into expanded Medicaid benefits. For example, five of the affected States -- Alaska, Delaware, Nevada, New Jersey, and Wyoming --do not now cover the medically needy.

Removing the 50% minimum would shift significant additional costs to the budgets of the affected States. Some cuts in eligibility or optional benefits which would hurt beneficiaries would probably result in almost all these States, but changes would not be uniform since each State would use its own current program as a starting point.

The Administration does not think that removal of the 50% minimum Federal support of State Medicaid expenditures would be preferable to imposing an interim cap on overall expenditures. Most States faced with unmet Medicaid costs would choose to reduce optional services. This does nothing to constrain the escalation of costs for the most inflation-prone medical services (i.e., hospital services and long-term care). Furthermore, it offers no incentive for States unaffected by removal of the 50% minimum to reduce fraud, waste and abuse.

This approach penalizes high benefit States for their past generosity and could seriously disrupt arrangements for delivery of health care services in those States. It offers no flexibility for all States to reorient their Medicaid programs to deliver more effective care at lower cost. It would result in savings of only $6 billion, as estimated by CBO for the FY 1982-86 period. In contrast, approximately $15 billion in savings is projected for the same period by OMB as a result of capping Medicaid.

IMPACT OF MEDICAID CAP

Question: The Congressional Budget Office has argued that a cap on Federal Medicaid outlays will probably increase interstate variation in eligibility and benefits. Their reasoning is that the lower income states with the highest percentage of Federal support would experience the largest percentage cuts and hence have the greatest incentive to cut back on eligibility and benefits. To the extent these states already have programs with limited eligibility and benefits, the proposed Federal cap may increase interstate variation in benefits. In other words, the effect of the cap will fall disproportionately on those who are most needy. What is your response to the CBO Analysis?

Answer: It is not true that lower income states would experience the largest percentage cuts under this proposal; Federal expenditures under the proposal will be allocated among States so that each State will maintain its current relative share of Medicaid spending. The Administration believes that the degree of restraint required under its proposal to cap Medicaid can be achieved by States through the flexibility it allows them to modify costly current program requirements and the additional incentives it provides to reduce fraud, waste and abuse in their State-administered programs.

The proposed cap on Medicaid expenditures does not reduce the Federal spending level below actual FY 1980 expenditures. It does limit the rate of growth in Federal Medicaid spending for FY 1982 to 105% of FY 1981 outlays, and ensures that, thereafter, until permanent reforms can be enacted, the rate of Federal spending would rise only with the rate of inflation.

It is in no State's interest to further burden State and local resources by shifting truly needy indiividuals completely out of the program. The Medicaid cap proposal would protect the neediest current Medicaid beneficiaries against loss of basic benefits. In addition, the proposal will give States authority which they do not now have to take many steps which could make the program more cost-effective without hurting beneficiaries. Examples of such alternatives which States could pursue under the proposal include hospital reimbursement rates set on other than a reasonable cost basis, including prospective payment programs; competitive bid and bulk purchase arrangements for services such as durable medical equipment, laboratory services and some prescription drugs; targeting optional services for specific populations; and promotion of non-institutional long-term care arrangements.

We recognize that prolonged imposition of a cap on Federal Medicaid expenditures without relieving the pressures which contribute to inflation of health care costs could indeed result in shifting a significant cost burden disproportionately onto State and local governments. That is why the Medicaid cap has been proposed as an interim measure only. Once Medicaid's unconstrained growth is brought under control, the Administration intends to propose comprehensive legislation to remedy current distortions in the health care market that have led to the alarming inflation of health care costs and to initiate long-term Medicaid reforms.

RISING MEDICAID COSTS FOR STATES

Question: Most States have expressed concern over rapidly rising Medicaid costs. Many feel they have made as many administrative savings as are possible, and that in order to reduce costs they will either have to cut back on the number and kinds of services they pay for, or significantly reduce the numbers of people eligible for Medicaid services. What steps can the Federal government take to help decrease the burden that Medicaid costs are placing on state governments?

Answer: One step that can be taken is adoption of the Administration proposal to improve the cost-effectiveness of Medicaid. This proposal will enable States to more effectively provide care to the needy while operating within their budget constraints.

States currently do not have authority under the Medicaid program to take many of the administrative steps which could make the program more cost-effective without hurting current beneficiaries or further imperiling State and local budgets. For example, they cannot take advantage of economies of scale by buying in bulk and distributing to recipients items such as canes and wheelchairs; they cannot use competitive bid arrangements to purchase laboratory services; except for child care, they cannot target services to the populations most in need of them; and they must reimburse hospitals on a reasonable cost basis and therefore cannot fully utilize reimbursement approaches which encourage more efficient and effective delivery of services. The proposal would enable them to take such steps.

The Medicaid cap proposal eliminates excessive Federal mandates which have been an obstacle to cost control and permits States to modify their Medicaid programs in ways that would reduce costs. The Congressional Budget Office (CBO)estimates that if States were free to reduce hospital reimbursement levels by even 5%, the resulting FY 1982 savings would be $250 million; expanding competitive bidding could save about $90 million in FY 1982.

Capping Federal expenditures will also give the States additional incentives to reduce fraud, waste and abuse in their State-administered programs. Eligibility errors alone currently cost Federal and State governments an estimated $1.2 billion a year.

The Administration is proposing that the matching rate for automated eligibility systems for Medicaid be increased. This additional assistance will help States reduce the number of errors which are made in determining Medicaid eligibility. We are also proposing a number of other legislative changes which will facilitate more accurate eligibility determination and assist in recovery of amounts improperly paid to providers.

The Administration recognizes that the alarming escalation of Medicaid costs stems in large measure from the program's inability to affect the underlying cost-increasing bias in the health care system. This bias results from the insulation of all parties in medical care markets from the cost consequences of their decisions.

We view the proposed imposition of a cap on Medicaid expenditures as an interim measure only. During the 1983-86 period, we will initiate reforms to remedy these market distortions. These health financing and Medicaid reforms will be aimed at reducing the rate of health care cost inflation and improving Medicaid.

Question: If a State wanted to cut back on the services Medicaid pays for, in your opinion, which services could be cut that would have the least effect on access to good medical care?

Answer: The Administration prefers an interim approach that places a ceiling on Federal funding for the program and allows States greater authority and flexibility to meet the essential health care needs of their citizens in a timely and cost-effective manner. The Administration believes this can be done without jeopardizing basic program benefits for the neediest beneficiaries.

We recognize that eliminating or reducing coverage of optional Medicaid services would reduce program costs. However, we believe that the States themselves are in a better position than the Federal government to determine which, if any, such services might be cut without unduly affecting access to good medical care.

Question: Rather than eliminating certain kinds of services (for instance, dental care), several states have proposed limiting the number of times a Medicaid beneficiary may receive a certain kind of service; e.g. the number of outpatient hospital visits per year, etc. Has HCFA carried out any demonstration projects to study the effects of this kind of cutback, and how much money such changes might have?

Answer: No, HCFA has not sponsored demonstrations of this type of limitation.

Question: For the record, please provide a list of those States whose Medicaid programs appear to be having significant financial troubles.

Answer: Most, if not all of the States under the Medicaid program, are experiencing financial difficulties to varying degrees. These difficulties occur for various reasons. High unemployment, over time, causes increases in the recipient rolls. States are also experiencing decreased revenues. The rate of inflation in the health care sector is substantially above the general rate of inflation. The impact of the Asian and Caribbean refugee influx also adds to the financial obligations for some States. The above-mentioned items and other factors have a financial impact for the States at various times, but most States are currently seeking ways to amend their programs in order to be able to meet their obligations.

WELFARE DEMONSTRATIONS

Senator Inouye: The Committee would appreciate learning from the HCFA of its plans to implement the AFDC Welfare Demonstration project that was authorized in the Omnibus Reconciliation Act of 1980, Public Law 96-499. The Committee understands that the Congressional Budget Office has estimated that this particular provision will result in savings of $44 million by the end of its second year and accordingly, the Committee wants to make sure that it is implemented in a timely and expeditious fashion.

Answer: Plans to implement provisions of the Reconciliation Bill are under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

RECOVERING MEDICAID OVERPAYMENTS

Last year, GAO issued a report stating that HCFA had inadequate systems in place to collect overpayments in the Medicaid program.

Question: What steps has HCFA taken to force States to identify and collect overpayments?

Answer: HCFA central office and its regional offices are monitoring to a greater degree State overpayment activity. Improved recovery efforts have been implemented in the form of concentrated overpayment reviews, applicaton of uniform criteria for crediting the Federal Government with its share of Medicaid overpayments, and delegation of the Medicaid disallowance authority to the regional offices.

Regulatory provisions have been developed in the form of a Notice of Proposed Rule Making (NPRM) entitled "Medicaid Overpayment Reporting Requirements." The regulation sets standards for State performance in identifying and reporting overpayments to HCFA. The regulation includes a provision that would protect Federal monies in case of poor overpayment performance by a State.

Question: How much do you estimate is lost in overpayments each year?

Answer: An accurate estimate of amounts lost in overpayments cannot be made due to a lack of detailed information. All overpayments identified and reported by the States to HCFA are taken into account at the time of issuance of the quarterly grant award; the award is reduced by the amount of any reported overpayment. At this time we have no way of determining the number and dollar amount of overpayments unidentified and unreported. The system of identification and reporting is only as good as a State's resources permits. In addition, as sources of overpayments are identified corrective management actions are designed and implemented in an effort to eliminate further loss of overpayments from that particular source. Our analysis of all data available to us indicates unreported, rather than lost, overpayments of from $50 to $100 million annually.

MEDICARE CONTRACTING

One proposed method to reduce HCFA costs is to limit administrative costs by allowing private firms to bid competitively for fixed price and fixed rate contracts to pay Medicare claims.

Question: What results is HCFA having with fixed-price contracts for Medicare services?

Answer: There are five fixed price (experimental) contracts currently in effect. Under Part B:

1. The Maine contractor's performance has been satisfactory.
2. The Upstate New York contractor has corrected its initial difficulty in claims processing and is now considered to be one of the better contractors within the New York region.
3. The Illinois contractor has experienced workload processing problems. While this contractor has shown some improvement, the Health

Care Financing Administration continues to monitor its performance in order to generate further improvements.

The Part A experimental contracts (New York and Missouri) have not been fully implemented, however the transitions are proceeding smoothly and HCFA expects the operational phases to be successful.

Question: A recent GAO report was quite critical of the fixed-price contracting experiment in Illinois. What steps is HCFA taking to improve beneficiary service in Illinois?

Answer: The Health Care Financing Administration has identified areas of serious concern and has directed the contractor to undertake corrective action. In addition, HCFA will conduct a special evaluation of the contractor's overall performance in order to determine whether its performance has improved sufficiently to warrant a continuation of the contract in its present form.

Question: By what date might HCFA be sure enough of the fixed-price contracting concept to attempt it on a nation-wide basis?

Answer: The matter is currently under review by Secretary Schweiker. Once the new administration's policy has been established it will be provided to the Subcommittee.

MEDICAID DRUG COSTS

From FY 1980 to FY 1981, your estimates of Medicaid costs for drugs increase 15 percent, from $690 million to $794 million; from FY 1981 to FY 1982, the estimates are up 10 percent, from $794 million to $879 million.

Question: How accurate have your estimates for drug costs been over the last few years?

Answer: Based upon comparisons of the original budget estimates to the calculated actual expenditures for drugs in fiscal year 1977, fiscal year 1978, fiscal year 1979 and fiscal year 1980, the estimates have varied from 7 percent under in fiscal year 1977 and fiscal year 1980 to 19 percent over in fiscal year 1978 and 13 percent over in fiscal year 1979. Budget estimate accuracy on a type of service basis is not a good indicator of forecasting accuracy because many States project growth on a total program basis and not on a discrete service type basis. Consequently, individual service categories may vary considerably more than the total dollar forecast.

Question: What effect, if any, is the MAC (Maximum Allowable Cost) program having on restraining the increase in the cost of drugs?

Answer: The MAC program is estimated to save the Federal and State governments $15 million per year. Additional benefits from this program may also reach the private citizen because physicians who prescribe generically for Medicaid patients are more likely to prescribe generically for their self-paying patients. Likewise when pharmacists stock lower cost generics for their Medicaid patients, it is to be expected that they will select these same products for their self-paying patients.

There is additional evidence of the effects of the MAC limits in restraining drug costs. In 1979, for instance, the average price of new prescriptions increased by 9.2 percent overall, and by 3.9 percent for the twenty most frequently prescribed generic drugs. By contrast the average price for eight of the top twenty drugs for which MAC limits were in effect actually decreased by 1.1 percent.

Question: How does the MAC program work?

Answer: The Maximum Allowable Cost program is an HHS wide program to reduce the program cost of certain multiple source drugs. It sets upper limits for reimbursement under Medicare and Medicaid and for drugs purchased and dispensed through the Department's Indian and Public Health programs. MAC limits are only set on drugs meeting the following criteria: The drug must be multiple source, i.e., sold by more than one supplier or under more than one name by a single producer; there must be a wide variation in prices among sellers; there must be considerable Federal expenditures for the drug; and the drugs must be therapeutically equivalent.

The program is administered by the six members of the interdepartmental Pharmaceutical Reimbursement Board and the seven staff members assigned to the Board. For the drugs determined by FDA to be therapeutically equivalent, the Board publishes proposed MAC limits in the FEDERAL REGISTER and requests comments over a minimum of 30 days. The Board conducts a public hearing to accept comments from those requesting a hearing. The Board then proposes final MAC limits to the Administrator of HCFA. If the Administrator concurs, final limits are published in the FEDERAL REGISTER and become effective in 45 days.

Currently there are in effect 44 MAC limits covering various dosages and forms of 21 drugs.

MEDICAID QUALITY CONTROL ESTIMATES

HHS' Bureau of Quality Control has responsibility for compiling data on error rates in each State. This information is used to determine whether any State is liable to a fiscal sanction for error rates which exceed Federally established targets. The Bureau calculates error rates according to a "combined regression estimate".

> Each State takes a statistically valid sample of its Medicaid case load and checks it for errors. HCFA then takes a subsample for errors. If HCFA finds an error where a State has certified a correct payment, this vastly increases a State's error rate. Example: For July-December 1978, California found its error rate to be 9.5%; using the Combined Regression Estimate HCFA determined that the error rate was 7.5%, based on its discovery of eight errors which California State officials had not found.
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> Last year, the directors of the State welfare and Medicaid programs voted overwhelmingly at a national conference to urge HCFA to revise and improve the Combined Regression Estimate.

Question: What has HCFA done in response to the criticism of the State Welfare Directors?

Answer: HCFA has improvements to the combined regression estimate under active consideration. The considered change will be presented to the State Medicaid Directors' Meeting in Philadelphia in April. In response to questions raised regarding the regression formula procedure for computing error rates, HCFA contacted statistical experts at major universities for their opinions and recommendations about the procedure. The statisticians have concurred that the regression methodology is appropriate and that the original rationale for using payment amounts as weights was correct. However, HCFA experience with the Medicaid Quality Control (MQC) data indicates that some of the original assumptions on which the weighting decision was founded may no longer hold. Thus, a change to case amounts as weights may be desirable.

Question: How many States are liable for a fiscal penalty according to HCFA's latest error rate data? Which ones?

Answer: Based on April-September 1979 data (the latest published data), there are 18 disallowance-liable States. They are:

State	Target Error Rate	Actual Error Rate
Maine	12.3	18.7
Massachusetts	6.2	8.6
Vermont	6.2	9.9
Delaware	7.8	11.1
Maryland	6.2	6.5
Florida	6.2	10.8
South Carolina	6.2	7.1
Tennessee	6.2	8.4
Illinois	6.2	8.0
Arkansas	6.2	11.1
Louisiana	6.2	6.4
Oklahoma	6.2	6.8
Iowa	8.5	11.7
Colorado	6.2	7.1
Montana	8.9	15.7
North Dakota	6.2	6.5
Wyoming	6.5	8.9
Washington	6.2	6.6

In order to foster reductions in error rates and establish a cooperative relationship with the States, the Department decided to suspend disallowances for States submitting and implementing sound corrective action plans. The disallowances in all disallowance-liable States have been suspended based on planned and ongoing corrective actions reported to HCFA.

The Department adopted this strategy because:

- imposition of disallowances would not aid the corrective action process and could hinder it through encouraging an adversarial relationship.
- The process of corrective action flowing from MQC findings is resulting in improved management of the Medicaid program.

APPENDIX I

Resolution Relating To Department of Health and Human Services
Medicaid Regression Estimate As Adopted By The National State
QC Public Welfare Directors Association At Their Annual Meeting In
Denver, Colorado, April 23, 1980.

Whereas On April 1, 1978 HEW-HCFA mandated a national Medicaid Quality Control Program on all states in 42 CFR 450.25(e) and subsequently, in 42 CFR 431.601 issued the "Fiscal Sanction" regulations which will penalize states that have an unacceptable Medicaid dollar payment error rate as determined by HCFA.

Whereas HCFA has developed without benefit of regulation or public discussion a method called the "Combined Regression-Estimate" to calculate each state's error rate, which assumes that there is a constant variability between state findings and federal findings among the various Medicaid programs being reviewed.

Whereas This assumption is not true for many states.

Whereas The HCFA report on the July-December, 1978 base period error rates significantly overstates the combined Medicaid error rate for many states, because when the "Combined Regression Estimate" is applied when it is not appropriate, it gives a disproportionate weight to the program that has the largest difference between state and federal findings.

Whereas Discussions and written comment by several states to HCFA regional and central offices have not produced any change in the federal methodology and HCFA central office staff have shown no interest in meeting with state staff individually or collectively to openly discuss the "Combined Regression Estimate" and the federal assumptions.

Therefore Be it resolved that the officers of the National State Public Welfare Quality Control Directors Association are directed to seek public discussion and comment with HCFA leading to changes in the methods used in estimating the states' Medicaid dollar payment error rate.

Therefore The Association's President is directed to file a copy of this resolution with HCFA central office, to make a copy available to each state Medicaid Director for use at the National Medicaid Director's Association meeting in Memphis, Tennessee and to submit a copy for discussion to the APWA Quality Control Subcommittee.

SUPPLEMENTARY MEDICAL INSURANCE CONTINGENCY RESERVE

Question: A large part of the requested increase for Supplementary Medical Insurance is to build up a contingency reserve in the account. For FY 1981 and FY 1982, this buildup of the contingency reserve accounts for $1,263 billion. Why must such a large sum be appropriated for a cotingency reserve?

Answer: The law requires that the SMI program be financed on an incurred basis. Because of the delay between the time a service is incurred and the time it is paid for out of the trust fund, a considerable balance or reserve must be retained as provision for incurred but unpaid benefits. In addition, a contingency reserve must be retained to amortize projection errors in the SMI actuarial rates, which determine the SMI appropriation.

A portion of the contingency reserve which existed on June 30, 1979, was used to amortize a small projection error in the SMI acturial rate for the period ending June 30, 1980. Current projections indicate that the remainder of the contingency reserve will be amortized by June 30, 1981. Thus, the appropriation request for FY 1982 includes an additional amount to begin rebuilding the contingency reserve to an appropriate level.

Question: What would be the negative consequences, if any, if the Committee provided less than the amount requested for a contingency reserve? Please be specific.

Answer: If our current projections hold true, the SMI trust fund could continue to pay benefits as they become due, even if the contingency reserve were reduced to zero. Providing less than the amount requested for the contingency reserve will ,however, reduce the degree of protection against random, unpredictable fluctuations in outlays and thus increase the probability that the trust fund could become unable to pay benefits when due. We believe that a substantial degree of protection against that risk is justified to ensure that our enrollees receive the benefits for which they have paid their monthly premiums. Our request for the contingency reserve provides this protection.

It is also important to keep in mind that the relative size of the contingency reserve is extremely sensitive to even minor projection errors. This is because of the timing of the promulgation of the actuarial rate which determines the appropriation. The actuarial rate must be promulgated before it can be determined, with any certainty, whether the actuarial promulgation in the previous year was adequate. Thus, in effect, each appropriation includes a correction for the period two years prior, as well as an estimated correction for the previous year. A large contingency reserve is necessary to compensate for this adjustment lag and ensures the financial stability of the program.

SUPPLEMENTARY MEDICAL INSURANCE

Question: The Budget Justification of the Supplementary Medical Insurance program states that there are three factors driving the increase in cost for this program. One of these factors is listed in the Budget Justification as "program increase," in both FY 81 back costs and projected FY 82 costs. For FY 81 and FY 82 combined, this accounts for $2.55 billion of the requested increase. How much of this increase can be attributed to mis-estimates of program costs?

Answer: The original benefit estimate for the SMI program for FY 1981 was $11,413 million. The current estimate is $12,305 million, a revision of the original estimate by $892 million. The actual amount of the mis-estimate will, of course, not be known until the actual results for FY 1981 have been determined. However, assuming that our current estimate is on target, 40% of the program increase referred to in the budget justification is the impact of the underestimate of FY 1981 on FY 1981 and FY 1982. The remaining 60% of the $2.55 billion represents the normal program increase.

The table below compares past estimates of program costs for both the Hospital Insurance and Supplementary Medical Insurance programs for recent fiscal years. Given the uncontrolled nature of the Medicare program, these estimation errors are within acceptable limits.

BENEFIT OUTLAY ERROR RATES - HI PROGRAM

FY		% Error One Year Projection	% Error Two Year Projection
1980		-4.3%	-2.6%
1979		1.7	3.2
1978		0.7	2.3
1977		1.8	1.2
1976		-0.7	-7.2
	Absolute value average	1.8%	3.3%

BENEFIT OUTLAY ERROR RATES - SMI PROGRAM

FY		% Error One Year Projection	% Error Two Year Projection
1980		-4.7%	-5.5%
1979		-0.4	1.8
1978		3.3	6.9
1977		2.3	0.7
1976		0.3	-11.3
	Absolute value average	2.2%	5.2%

BENEFIT OUTLAY ERROR RATES - HI PROGRAM

Question: What can be done to improve the accuracy of estimates in SMI costs?

Answer: The SMI actuaries are continously striving to make improvements methodology and data processing procedures in order to improve the accuracy of the SMI estimates. However, the very nature of the SMI program makes it impossible to achieve accuracy beyond a certain level. For example, physician utilization patterns, which fluctuate randomly from year to year, play a significant role in determining SMI benefit payments but are impossible to predict. Also, forcasting the impact of inflation on provider payments is a difficult task.

Because of the large random fluctuations which can occur in the SMI benefit payments, it is important to carefully plan the financing of the program. This is the reason why the SMI trust fund balance includes a contingency reserve.

Question: What can be done to contain the cost of this program?

Answer: This issue is currently under discussion within the Reagan Administration. An initive to strengthen competition in the health care sector is being developed for implementation in FY 1983. We believe that it will have a significant impact on program expenditures.

Question: How much is the number of beneficiaries for Medicare Part B services increasing from year to year?

Answer: During recent years, the overall number of SMI enrollees has been increasing at a rate of about 600-700 thousand per year. This is a growth rate of about 2-3% per year.

CONCURRENT REVIEW VS PROSPECTIVE AND RETROSPECTIVE REVIEW BY PSROs

PSROs rely primarily on "concurrent review" of hospital admissions to determine whether they are medically necessary. In order words, a patient's medical record is reviewed while he or she is in the hospital.

It has been suggested that either prospective (before admission) or retrospective (after discharge) review would be a much more efficient way to monitor the appropriateness and necessity of Medicare and Medicaid health care services.

Question: What experiments, if any, are PSROs carrying on in the area of prospective and retrospective review?

Answer: PSRO experience with prospective and retrospective review cannot be considered experimental, since all PSROs have adopted a retrospective component, and nearly 1/2 have ongoing preadmission initiatives. Before PSROs shifted to a focused concurrent review system. PSROs relied primarily on 100% concurrent review to determine the medical necessity of admissions and continued stays. As PSROs became more familiar with health care patterns in their areas, and as PSROs responded to tighter budgets in 1978 and 1979, PSROs turned to a focused review system where only problem cases are reviewed concurrently.

All Medicare and Medicaid admissions in PSRO areas are reviewed retrospectively through profile analysis. The profiles are used by the PSRO to analyze diagnostic-specific and physician-specific admitting patterns. Subsequently, PSROs initiate concurrent or preadmission review based on identified problems in admissions or continued stays.

On the other hand, some PSROs have experimented with a retrospective case review approach. This is a chart review of an admission or continued stay performed in the facility after discharge, but before the patient's bill is certified for payment purposes. Some PSROs, particularly large state-wide PSROs with many small hospitals, have adopted this form of retrospective review.

Prospective or preadmission review is increasingly emphasized by PSROs, especially in relation to elective surgery. HCFA has distributed data on pre-operative stays and weekend admissions. PSROs with problems in these areas are expected to take corrective action. However, because preprocedure review is relatively expensive, it is not in common practice.

Question: Are there any data showing the effectiveness of these kinds of review relative to concurrent review?

Answer: There are some isolated case studies, but no national evaluation has studied this question. Therefore, no conclusive data are available.

PSROs AND RECENT GAO REPORT ON POOR PERFORMANCE AND MONITORING

A recent GAO (HRD 81-26) report looked at the records of 809 patients who had had 1779 days of hospital care denied for payment by PSROs, and found that in those cases, the PSROs ought to have denied an additional 384 days of care.

In essence, what GAO's study seems to indicate is that even when PSROs do exercise their power to deny Medicare or Medicaid payment for unnecessary days of hospital care, many of them do so inexactly and inefficiently.

Question: What steps is HCFA taking to respond to GAO's critique and to improve the performance of PSROs?

Answer: The GAO report was critical of PSROs because days that the GAO determined were not medically necessary were paid. Of the cases cited, 24 cases representing approximately 30% of the unnecessary days were paid because the patients were awaiting placement in a long term care facility. In areas where there is a shortage of long term care beds, HCFA policy permits payment for the days of care for patients awaiting placement. The remaining unnecessary days of care should be viewed as the fault of the PSRO and its delegated hospitals, where involved. HCFA had already taken action, described below, to monitor PSROs more carefully.

In June 1980, HCFA implemented a revised PSRO monitoring system. It consists of two components - a PSRO Monitoring Report set and the Regional Assessment Report. The PSRO Monitoring Report gathers comprehensive information on each PSRO's activities. It is completed by the project officer and submitted annually. The Regional Assessment Report is designed to identify areas in need of technical assistance.

Question: By what standards does HCFA presently monitor and gauge the effectiveness of PSROs?

Answer: The essential evaluation approach is anchored in the PSRO objective setting process. PSRO objectives are scrutinized for their appropriateness given the health care problems in the area, and for the extent of progress the PSRO makes in this area.

Some PSROs have developed cost-benefit ratios, but no recent estimates have been done by HCFA. Given potential challenges of the method that would be used by HCFA, and challenges to the measurement of PSRO effectiveness in general, HCFA has not embarked on this course.

Question: What can HCFA do to improve the monitoring of PSROs to determine which are performing better than others?

Answer: The monitoring systems described above represent HCFA's present effort to improve the monitoring of PSROs.

PSROs AND NON-FEDERAL PATIENTS

It has been reported that some private firms, notably Caterpillar Tractor Co., and Deere and Co., have contracted with PSROs to monitor hospital utilization of their employees.

Question: Does HCFA have any information as to how many PSROs are engaged in review of non-Federal patients?

Answer: Approximately 50-55 PSROs have contracts to perform review for 49 companies covered by 53 insurers.

Question: Is there any data showing what effect these might be having on utilization?

Answer: PSROs are not required to report to the Department on their private review impact. However, some of the companies think the review is quite effective. The Caterpillar Tractor Company, for one, claims that PSRO review, at an average of $15 per admission, has produced:

- + 10% lower admissions
- + 19.2% decrease in days of care per 1,000 covered persons
- + 10.3% decrease in length of stay

Question: When a PSRO contracts with private-sector firms, does this help reduce the administrative and overhead costs of the PSRO?

Answer: Yes. The actual savings to the Federal Government vary by the amount of outside contracting a PSRO does and how the overhead costs are apportioned.

PSROs - QUALITY ASSURANCE

PSROs have a dual responsibility: to review "quality assurance," that is, quality of treatment beneficiaries of the Medicaid and Medicare programs receive; and to monitor utilization of services of those beneficiaries.

Question: What evidence is there that PSROs are having any influence on the quality of care and treatment that Medicare and Medicaid beneficiaries receive?

Answer: The quality review component is a major feature of the PSRO program. The 1979 PSRO program evaluation documented positive impact from PSRO quality assurance efforts. This study showed that when Medical Care Evaluation (MCE) studies identify significant problems, improvement can be observed when the MCE is repeated. This effect was not just experienced in one or two places, but was demonstrated on average in the entire group of PSROs studied.

Question: For the record, please provide several examples of PSRO activities which have improved quality of care for Medicaid and Medicare beneficiaries.

Answer: There are numerous examples of PSROs' successful efforts in areas where there had been deficiencies in the quality of care. The following are of note:

A PSRO found that the rupture rate on primary appendectomies was 44% for one hospital compared to an areawide average of 11.4%. Through an intensive newspaper campaign in this hospital's service area advising readers of appendicitis symptoms as well as the risks involved with a ruptured appendix, the need for quick medical attention was emphasized. As a result the rupture rate has decreased from 44% to 15.6%.

Another PSRO discovered a problem concerning the overutilization of physical therapy services in two hospitals as documented by an on-site monitoring of delegated review. A peer review conference with several physicians and the PSRO's request for a specific plan of corrective action from each hospital's physical therapy department and administration represented the PSRO's program to correct the problem. When the plan of correction was not received by the PSRO, it began deleting charges for unnecessary services in cooperation with the Fiscal Intermediaries. In one hospital a corrective plan is still being implemented. In the second, a 50% reduction of the physical therapy patient load and a 38.6% reduction in the number of procedures per patient was achieved.

An urban PSRO, with support from its Health Systems Agency (HSA), developed a detailed report on the causes of neonatal mortality in its area for a specific period. The report clearly identified hospital-specific variations in quality of care delivered to high risk mothers and infants. Plans for corrective action are underway.

A regional profile identified the length of stay for nonsurgical treatment of gastric peptic ulcer. The PSRO compared itself with others and saw it had a length of stay 20% greater than the regional average. The PSRO, through on-site visits, offered direction in curbing the problem. The problem was resolved. Analysis of recent data identified an average length of stay within the regional length of stay.

PSRO REVIEW OF MEDICAID UTILIZATION

Question: The PSRO program has statutory authority to review both Medicare and Medicaid utilization, yet it has no data on the effect of PSROs on the Medicaid program. Does HCFA have any knowledge of what effect, if any, PSROs have on Medicaid utilization?

Answer: While many attempts have been made to study the PSRO effect on Medicaid, few conclusions can be drawn. The 1979 PSRO evaluation reported a preliminary Medicaid Rate Study. Four PSRO case studies were presented. We were unable to draw any conclusions from these case studies because the results were so varied. We know from these case studies that aggregate Medicaid utilization counts, and therefore rates, fluctuate substantially from quarter to quarter and there is wide area variation. This could be caused by: data artifacts or changes in reporting, variation in out-migration, short-term eligibles. There is no basis to generalize the results of these case study analyses to estimate national Medicaid trends or to predict PSRO activity.

The PSRO data are of limited use for rate analysis for national PSRO evaluation efforts because we are unable to calculate rates with them. While one might make best estimates or educated guesses for some purposes, it is inappropriate for objective and credible evaluation to make generalizations of a PSRO effect on Medicaid utilization in the absence of reliable data.

Question: When might data on PSRO review of Medicaid utilization become available?

Answer: HCFA continues to work toward obtaining suitable Medicaid data to support research, evaluation, and actuarial estimates. Assuming that our plans to develop reliable person-based Medicaid data systems proceed according to schedule, we would hope to have national multipurpose Medicaid data by late 1983 that would be suitable for PSRO evaluation.

FINANCIALLY DISTRESSED HOSPITALS

Question: What initiatives is HCFA planning to help prevent the closure of Financially Distressed Hospital?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: How many "Demonstration Grants" have been awarded to Financially Distressed Hospitals?

Answer: During FY 1980 two demonstrations were started in New York City that involved financially distressed hospitals. In September 1980 a grants solicitation was published for additional demonstrations involving financially distressed hospitals. In response to that solicitation, three additional demonstrations have been awarded in Jacksonville, Florida; Boston, Massachusetts, and Los Angeles, California.

Question: What steps are being taken to help assure that more and more hospitals do not face severe financial difficulties?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

UNIFORM BILLING

Question: HCFA has been developing and testing for a number of years, uniform billing, cost, discharge and utilization data. What steps has HCFA taken to work in concert with private sector health care providers and insurers to devise similar reporting forms for both private and public health care services?

Answer: HCFA is making a concerted effort to work with the industry, including provider groups and health care insurers, to assure that industry needs as well as HCFA needs are met. Most recent examples of HCFA/Industry cooperation are evident in policies to standardize billing forms and formats. A recently completed evaluation of uniform billing took into consideration the opinions and experiences of a wide range of providers and insurance companies. HCFA is now working in cooperation with the American Hospital Association's National Uniform Billing Committee to finalize a uniform bill for potential use by all hospitals and insurers. HCFA recently released specifications for magnetic tape billing. The tape specifications were designed to meet the reporting needs of Federal, State and commercial third-party payers.

Integrated data management systems are being demonstrated in States throughout the country. The demonstrations are to cooperatively develop a streamlined system for collecting and processing hospital bill and discharge data in a manner that meets the needs of PSROs, health planners, rate-setters, hospital associations and third-party payors. Other examples include working with the American Medical Association to refine CPT-4 for physician reimbursement, and soliciting industry input on HCFA's long-range plans and policies by disseminating policy papers to industry representatives for comments.

Question: What is HCFA doing to try to reduce the Federal paperwork burden on the health care industry?

Answer: By promoting industry-wide standards for data definitions, minimum data sets and common codes, burdensome reporting can be substantially reduced. HCFA has been working with industry and government representatives to achieve industry-wide standards as illustrated by the examples such as uniform bill development, hospital tape specifications, integrated data systems, HCFA Common Coding System, and revenue coding.

In addition, HCFA has been working with other parts of this Department to streamline burdensome reporting resulting from similar reporting requirements imposed by different programs within HHS as well as by other government agencies. Through the Department's Health Data Advisory Committee (HDAC), HCFA is examining reporting requirements for Health Maintenance Organizations (HMO's). Work being done under a HCFA grant with Group Health Association of America to design an HMO uniform reporting system will assist HCFA and HDAC in making recommendations to streamline HMO reporting requirements. An Intra-Departmental group which HCFA co-chairs is overseeing the development of a consolidated quality control system for Medicaid, AFDC and Food Stamps.

MEDICAID BENEFICIARIES

In the past few years, the number of Medicaid beneficiaries has continued to rise at a steady gradual pace. The FY '82 estimate shows an increase of 459,000 beneficiaries over FY '81, a 2.5% increase, for a new total of 18,783,000 recipients of Medicaid service.

Question: What are the main economic and other factors that cause the number of beneficiaries to increase?

Answer: A steady but gradual increase in the number of Medicaid beneficiaries occurs because of changing economic conditions. The principal reason for an increase in the number of recipients eligible to receive benefits in the Medicaid program is the rise in and continuation of the unemployment rate which eventually increases the number of individuals eligible for the Medicaid rolls. In addition, there have been changes in the types of services offered by the States which result in expanded benefits, but also indirectly expanded the eligibility requirements. Also, the aged population has been gradually expanding and a number of these individuals are entitled to Medicaid.

Question: Over the last few years, which segment of the population has shown the most marked growth in eligibility for and utilization of Medicaid services?

Answer: The segment of the population showing the most growth in eligibility is the children in the Aid for Families with Dependent Children category. Conversely, the elderly constitute the segment of the population showing the most marked growth in Medicaid services over the past few years. Because of the recurring health problems of the elderly, this group now utilizes more services offered under the Medicaid program than any other segment of the population.

PSROs AND MEDICAID

The Carter Administration's budget justification assumes $22 million in Medicaid savings due to PSRO review.

Question: In how many States do PSROs review all Medicaid hospital cases?

Answer: PSROs perform review in all States except Nebraska where there never has been a PSRO. The Texas PSRO, which recently completed its planning phase, is not yet reviewing all Medicaid admissions. Ohio, Florida, California, and Tennessee have uncovered areas. Where there are no PSROs in these uncovered areas, the States do their own Utilization Review.

Question: For the record, please provide a list of the percentage of Medicaid hospital cases PSROs review in each State.

Answer: PSROs review all Federal patients, including all Medicaid patients, through concurrent review and retrospective profile analysis. When patterns of appropriate utilization exist, PSROs do not review the patient care concurrently. Rather PSROs focus concurrent review on problem areas with the resources the PSRO has available.

PSROs are not required to report to the Department the payment source of patients reviewed concurrently. Without such data, and knowing that PSROs continually change the problem areas they review, it is not possible to estimate the number of Medicaid patients being reviewed concurrently. For hospitalized Medicare and Medicaid patients as a whole, however, PSROs concurrently review approximately 40-50%.

MEDICARE CONTRACTORS

The Health Care Financing Administration (HCFA) has used its experimental authority to undertake several contract initiatives in connection with the administration of the Medicare program. Specifically, some of these initiatives include competitively determined fixed-price and fixed-rate contracts to pay Medicare claims.

Question: Would you estimate for the Committee any estimated savings that have accrued from the shift from cost reimbursement to competitive selection of Medicare contractors?

Answer: Provided below is our estimate of administrative cost savings resulting from competitive selection of Medicare contractors.

	Savings
Part A	
Missouri	$ 2,000,000
Part B	
Upstate New York	16,471,100
Illinois	33,477,900
Massachusetts-Maine	1,281,600
Total	$53,230,600

In addition to the above, the Health Care Financing Administration has negotiated a Part A experimental contract for the State of New York. These savings are expected to be $5,755,900.

Question: Are you now prepared to seek legislative authority to permit selection of Medicare contractors competitively on a permanent, rather than experimental basis?

Answer: The matter is currently under review by Secretary Schweiker. Once the new administration's policy has been established it will be provided to the Subcommittee.

REDUCING MEDICAID COST

Question: It has been suggested that the most effective way to reduce the cost of an entitlement such as Medicaid is to either reduce benefits or restrict eligibility for the program. Is there a sensible way to restrict eligibility for the Medicaid program, so that program costs can be contained, but essential services will not be denied to the needy?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the subcommittee.

PSROs - MEDICARE PART A COSTS

The PSRO program has been in existence since 1974. Since then, according to the attached table, Medicare (Part A) hospital costs have increased 294 percent from $8.0 billion to $31.8 billion.

The only data HCFA has ever submitted to demonstrate the cost-saving effectiveness of the PSRO program are for the Medicare (Part A) hospital program.

Question: Don't the figures cited above indicate that even if the PSRO program has a modest benefit-to-cost ratio of 1.3 to 1, as HCFA claims, the program is ineffective in checking the growth of Medicare costs?

Answer: PSROs' review effort is geared towards reducing unnecessary days of care. It is difficult to determine how much of the $23 billion increase since 1974 was due to unnecessary days of care. Other factors that have contributed to the rise in health care costs include excess supply of hospital beds, increased costs of necessary goods and services, inflation, costs associated with changes of technology, and the increase in the number of days of care. PSROs can have an impact on the number of days of care only to the extent to which these are unnecessary.

HEALTH CARE FINANCING ADMINISTRATION
Outlays FYs 1972-1982
(dollars in thousands)

	FY 1972	FY 1973	FY 1974	FY 1975	FY 1976	FY 1977	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982
Medicare:											
Part A	$6,275,514	$6,841,661	$8,064,753	$10,611,532	$12,578,627	$15,207,149	$17,861,676	$20,343,031	$24,287,539	$27,020,951	$31,850,014
Part B	2,543,696	2,637,099	3,282,799	4,169,855	5,200,093	6,341,666	7,349,594	8,804,699	10,746,318	13,001,594	15,194,238
Medicaid:											
Appropriation	4,278,662	5,761,245	5,000,000	6,966,375	8,501,026	10,193,193	10,699,000	11,785,589	14,555,139	16,581,598	18,336,203
Outlays 1/..	4,138,167	4,979,218	5,833,233	7,056,374	8,306,295	9,727,199	10,679,881	12,407,317	13,956,700	16,483,493	18,214,808

1/ Prior to FY 1978, Medicaid outlays are not readily available. FY 1972-FY 1977 date represents expenditures.

MEDICARE - HOME HEALTH CARE

Until the adoption of the Omnibus Reconciliation Act of 1980, proprietary (or for-profit) home health agencies were eligible to participate in the Medicare program only where the agency was licensed pursuant to State law and met certain additional requirements prescribed in Federal regulations. Only 24 States presently license home health agencies, with the result that proprietary agencies have been precluded from participating in Medicare in a number of States. The Medicare amendments contained in P.L. 96-499 provide that, effective July 1, 1981, the special State licensing requirement will no longer be applied to proprietary home health agencies.

Question: What effect do you feel the recent change regarding State licensure requirements for proprietary home health agencies wishing to participate in Medicare will have on the program?

Answer: There will almost certainly be an increase in the number of home health agencies certified to participate. However, we anticipate that this change will not have a negative impact on existing home health agencies. We are unaware of any operational problems faced by existing agencies affecting beneficiaries associated with the existence of proprietaries in the States in which they currently operate. Additionally, we are unaware of any specific situations in which competition from a proprietary agency was a primary cause for previously established agencies to either withdraw from participation or to be subject to formal decertification action.

Question: How many additional home health agencies will participate as a result of this change?

Answer: An estimate of the projected number of new applicants is not yet available. Efforts geared toward quantification have been unsuccessful primarily because of two factors; i.e., first, it is doubtful that either the large proprietary organizations or the independently operating proprietaries have yet determined their course of action (or at least, we have not been able to perceive what action they may be considering), and second, it is also necessary to take into account State certificate of need (CON) and State licensure laws. Of the States which now permit proprietaries to operate by virtue of licensure laws, 19 also have CON laws in effect. These laws may have limited the growth of all types of home health agencies in their respective jurisdictions. The combined effect that these two factors will have on the number and rate of growth of home health agencies cannot be ascertained, and attempts at this time to determine their effect are, at best, speculative.

Question: Will this enable more Medicare beneficiaries to avail themselves of home health care?

Answer: The location of agencies will have a significant bearing on this question. Metropolitan areas devoid of adequate home health services will, if chosen by proprietaries as areas in which to operate, be able to supply a new agency with patients heretofore not treated by the existing provider population. However, these same areas, if saturated with home health services, will not be able to supply new patients and, therefore, both the existing agency(ies) and the new agency(ies) will be attempting to render services to an existing and possibly stable patient caseload.

The majority of existing home health agencies are now situated in areas with some degree of population density, with relatively few located in areas devoid of population below the level which is needed to assure their continuing viability. New agencies forming in areas of population sparsity, depending on their ability to withstand varying degrees of financial vulnerability, would be in a position to offer home health services to beneficiaries who might not otherwise be able to receive such services.

Question: Are you initiating any new or expanded efforts with regard to fraud and abuse detection now that proprietary agencies will be participating in greater numbers?

Answer: Fiscal irregularities have been found to be present with respect to the operation of various types of home health agencies, including proprietary home health agencies; however, there are no indications that the patient care services rendered by any one type of agency differs from services rendered by the others. Therefore, except for strengthening the program evaluation requirement as it currently exists in the home health agency Conditions of Participation, which is applicable to all types of home health agencies, we believe that special requirements are not necessary for proprietaries.

However, HCFA has taken steps to more appropriately assure proper reimbursement to all home health care agencies, and these actions will be equally applied to newly participating proprietary agencies. The Home Health Agency Task Force, created in 1979, initiated a number of activities, including:

A. Intensified Intermediary Audits - As a result of HHA abuse problems noted in the State of Florida, a special project was initiated requiring intermediaries to perform "intensified audits". Two audit guides were developed; one to probe the fiscal aspects of facilities' operations, and the other to conduct medical necessity/coverage reviews. Sixty-six (66) home health agencies in Florida have been audited using the fiscal audit guide and $1.5 million in audit adjustments were made. Medical audits have been conducted on 850 patients treated by 64 facilities with 20,940 visits rendered and 19,750 (94.3 percent) considered to be covered.

The intensified audit guides will be used in various parts of the country on a selective basis to assure HHA compliance. It is currently being used by intermediaries in the Dallas region in addition to Florida, and is intended for use in other regions in the near future. These audit activities will be monitored and maintained until the audits are no longer cost effective.

B. The Home Health Agency Validation Reviews - The Office of Program Validation focused much of its 1980 validation review program on home health agencies. To date, 23 HHAs have been reviewed and recommended audit adjustments of over $1.2 million have been made. Although HHAs will not be similarly focused in the 1981 validation activity, we believe problems persist and will perform reviews on a limited number of agencies. We believe the preferred approach is more intensive fiscal and medical audit activity on the part of fiscal intermediaries.

C. The Home Health Agency Data Project - The Home Health Agency Task Force recognized that a greater capacity was needed to target HHAs for special review and audit. It was concluded that a special request to intermediaries was needed to solicit cost and utilization information.

Replies to the data request have now been received in HCFA central office. The data is being used to identify agencies to be reviewed as part of the program validation effort, the HHA Cost Report Evaluatin Program (CREP), and the intensified audit and medical review underway in several areas of the country.

In order to better facilitate detection of fraud in the Medicaid program, the HCFA is planning to implement a study to test programs for recipient verification of Medicaid services. The intent of an effective Medicaid verification of services program is to determine from recipients whether services paid by the Medicaid program were actually rendered to those recipients.

MEDICAID MANAGEMENT INFORMATION SYSTEMS (MMIS)

Many States have been very slow in developing and implementing a Medicaid Management Information System (MMIS) as required by law. Now, however, they are required to have an approved MMIS on line by September 30, 1982, or face financial penalties.

Question: How many States have an approved MMIS program as of today?

Answer: Thirty-four (34) States have received certification and approval for 75 percent Federal Financial Participation matching funds for their Medicaid Management Information Systems.

Question: What is the average percentage error rate in those States?

Answer: The average claims processing gross error rates for these thirty-four (34) States is 0.33 percent.

Question: How does HCFA review MMIS programs that are presently operating to make sure that they run efficiently and reduce error rates?

Answer: HCFA has recently developed a formal Systems Performance Review process for the periodic assessment of State adherence of previously certified State Medicaid Management Information Systems to the basic functional requirements and for measuring the operational performance of these systems against predetermined standards. The application of this Systems Performance Review will be the primary determinant for continuation of the State's eligibility and Federal approval for the 75 percent Federal Financial Participation for the Medicaid Management Information Systems operations.

Question: Are the States which to date do not have an MMIS program making a good-faith effort to have one in operation as soon as possible?

Answer: Our experience indicates that those States and the District of Columbia, which have not yet been certified, are making a good-faith effort to have an MMIS in operation as soon as possible. Of these States, four small States and the Territories of Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands also fall under the waiver conditions of recent legislation. Two States that were in development stages have experienced severe difficulties with their contractors but are continuing their efforts.

Question: Which States do not now have an MMIS program?

Answer: Arizona, the only State which does not have a Medicaid program is the only State which does not have an MMIS program activity nor does American Samoa.

Question: What is the average Medicaid error rate for those States?

Answer: The average claims processing gross error rate for the fifteen (15) States which do not have a certified MMIS is 1.04 percent.

CALIFORNIA REQUEST FOR REVIEW OF PSRO PROGRAM

Question: The California State Department of Health Services has written at least twice to HCFA to suggest a joint study of the relative impacts of different utilization review (UR) systems on the cost and quality of health care. Why has HCFA refused to participate in such a study and what efforts is HCFA making to encourage the development of alternate forms of UR as possible replacements for PSRO review?

Answer: These matters are currently under review by Secretary Schweiker. Once the Administration's policy has been established, it will be provided to the Subcommittee.

HEALTH CARE FINANCING ADMINISTRATION
FRAUD, ABUSE AND WASTE REDUCTION

Question: Please list all the offices in HHS charged with investigations of fraud and abuse under Medicare and Medicaid.

Answer: The Health Care Financing Administration is charged with the responsibility to investigate and/or to monitor the investigation of all cases of abuse in the Medicare program. The Health Care Financing Administration also has responsibility for conducting and/or monitoring the preliminary investigation of cases of possible fraud for referral to the HHS Inspector General. Specific offices and entities charged with these investigative responsibilities include:

The Office of Program Validation,
Bureau of Quality Control, HCFA;
HCFA Program Integrity Regional Offices;
Medicare Contractors (Carriers and Intermediaries)

Investigation of fraud and abuse in the Medicaid program is primarily the responsibility of the State Medicaid agencies and the State Medicaid Fraud Control Units in those States where units have been established. The Health Care Financing Administration's Office of Program Validation and the Program Integrity Regional Offices also provide oversight and technical support to Medicaid State agencies to ensure that they meet their fraud and abuse responsibilities.

Question: How are the activities of each of these coordinated?

Answer: The Health Care Financing Administration's Program Integrity Regional Offices maintain oversight and coordination among the Medicare carriers and intermediaries within their respective regions. Instances of possible fraud are investigated by the Medicare contractor and/or the Program Integrity Office only to the point where there is sufficient information to believe a strong potential for fraud exists. The case is then referred to the Office of Investigations, HHS Office of Inspector General for full investigation. Instances of abuse in Medicare are developed to resolution by the Medicare contractors which are monitored by the Program Integrity Regional Office. The Program Integrity Regional Offices also monitor and periodically evaluate the effectiveness of Medicaid State agency programs for detecting and controlling fraud and abuse and ensure compliance with Federal regulations requiring an effective fraud and abuse control system. Coordination among Medicare contractor investigations of abuse and Medicaid State agency abuse investigations is also facilitated through the Program Integrity Regional Offices. Monitoring and oversight of the State Medicaid Fraud Control Units is the responsibility of the HHS Office of Inspector General.

The Health Care Financing Administration's Office of Program Validation also reviews reports from the Program Integrity Regional Offices and Medicaid State agencies which detail the investigation of all Medicare and Medicaid abuse cases.

Question: What savings have been achieved by each of these entities as result of their anti-fraud and abuse efforts in the past year?

Answer: Medicare contractors and Program Integrity regional offices established $20.5 million in Medicare overpayments in Fiscal Year 1980. Medicaid State agencies established $30.3 million in Medicaid overpayments in Fiscal Year 1980.

Also, 195 validation review reports were issued in Fiscal Year 1980 as part of HCFA's Program Validation effort, and 245 reports have been issued to date. Estimated overpayments and savings identified from these reports exceed $100 million through Fiscal Year 1980. These savings estimates are a combination of:

1. overpayments identified specific to individual providers;
2. correctable operational deficiencies by Medicare contractors and State Medicaid agencies; and
3. policy changes which if implemented would result in savings.

Of the $100 million in savings identified, approximately $40 million relate to specific provider practices while the remainder are attributable to policy changes or operational deficiencies.

In addition, there were 87 administrative sanctions imposed upon providers, practitioners, and other suppliers who defrauded or abused the Medicare and Medicaid programs. In FY 1980 these administrative sanctions (suspensions, exclusions, and terminations) resulted in savings of approximately $4.8 million in FY 1980.

Question: How are the activities of these units coordinated with those of State Medicaid Fraud Control Units?

Answer: Instances of possible fraud that may be identified during a validation review are forwarded to the State Medicaid agency for possible referral to the State Fraud Control Unit, if appropriate. Also, as part of the State Medicaid Assessment Program, the Program Integrity regional offices ensure that State Medicaid agencies refer cases of potential fraud to the State Fraud Control Unit for further investigation.

In addition, State agencies are responsible to notify HCFA of convictions of practitioners for criminal offenses related to their involvement in the Medicaid program. Notification is necessary so that HCFA may initiate suspension action against the practitioners as required under Section 7 of P.L. 95-142.

Question: What changes, if any, are you contemplating to facilitate identification and prosecution of Medicare and Medicaid fraud?

Answer: To facilitate the identification and initial investigation of Medicare fraud, HCFA has provided new instructions and added responsibilities to Medicare carriers for the initial investigation (integrity review) of Medicare fraud complaints. As part of the State Medicaid Assessment Program, the HCFA regional offices are implementing new procedures for assessing a State's performance in all aspects of the Medicaid program. The review process has been revised to make it more objective and performance oriented. Objective, specific functional standards will allow State agencies to know in advance the level of performance which is acceptable and to better meet those standards.

Question: What is your current estimate of the dollars lost due to fraudulent and abusive activities under Medicaid and Medicare?

Answer: We are unable to provide a reliable estimate of the dollars lost due to fraudulent and abusive activities under Medicaid and Medicare. We believe it would be very difficult, if not impossible, to accurately quantify such a dollar loss.

Question: What specific actions are you taking to ensure that the Department of Justice is provided information on potential fraud?

Answer: Under the terms of the operating statement between the Health Care Financing Administration and the Office of the Inspector General, HCFA performs or directs an initial review of all complaints involving possible fraudulent activity. Once HCFA staff have sufficient information to believe a strong potential for fraud exists, the case is referred to the Office of Inspector General for full-scale investigation. The Office of Inspector General is responsible for determining whether a case should be presented to the Justice Department for prosecution. The Health Care Financing Administration may provide specific assistance to the Inspector General and the Justice Department on a particular case when so requested by the Inspector General or U.S. Attorney.

Question: What has impeded this activity in the past and have these problems been overcome?

Answer: The Health Care Financing Administration has been referring potential fraud cases to the Inspector General as required under the terms of the operating statement. The Office of Investigations' workload is growing at a greater rate than its work-force. This results in some cases being returned to HCFA for possible administrative action and other cases remaining unworked in the backlog.

The Inspector General has also cited the Office of Investigations' lack of normal law enforcement powers (e.g., arrest, search and seizure) as hampering OI's ability to handle certain phases of investigations. Because of this, some U.S. Attorneys assign HHS program investigations to other investigative agencies and OI loses control of the case. Timely actions then must be delayed while enforcement personnel from other agencies are assigned and briefed. The Inspector General is expected to develop recommendations in this area in the near future. The Health Care Financing Administration has also worked with OI to more accurately determine when a case should be referred to OI and to provide OI with all necessary information supporting the case.

STATE AND LOCAL ADMINISTRATION (QUALITY CONTROL PROGRAMS)

Question: What is the estimated cost of the Medicaid Quality Control program?

Answer: The total State and Federal yearly cost of the Medicaid Quality Control program is estimated at $30,000,000, based on staffing approximations and associated costs.

Question: What is the current and anticipated cost/benefit ratio for this activity?

Answer: Based on data from the April-September 1979 period, the current cost/benefit ratio for Medicaid Quality Control is .14; i.e., we anticipate a benefit of about $7.10 for each $1 spent. The benefit for this period was estimated by taking the difference between the national error rate for the period and the national error rate for the base period of July-December 1978. A 1 percent reduction was achieved in April-September 1979. This 1 percent was multiplied by estimated total Medicaid vendor payments for April-September 1979, yielding a dollar benefit of $107 million. This was divided into the estimated semi-annual cost of $15 million, as described in the previous answer.

Cost benefit ratios for FY 80-82 are approximately .27 or a benefit of $3.70 for each $1.00 spent. These figures are based on expected benefits for FY 80 under current regulations and benefits for FY 81 and 82 under Michel Amendment regulations. The benefit for each year is computed as the difference in error rates from the previous year multiplied by estimated expenditures in each State. The high cost benefit ratio for 1979 is attributed to the greater than anticipated decline in error rates in some States for that period.

In order to improve the cost/benefit ratio, HCFA is planning to reduce samples in those States which show consistently low error rates and to allow shifts in samples in other States to highly error-prone areas.

However, we view Medicaid Quality Control as more than cost saving. MQC assists States to properly manage their Medicaid programs thus insuring that maximum benefits go to those who are truly in need of them. The program helps insure that only those who are actually eligible for benefits receive them, and that the benefits they receive are in the correct amounts. Thus, funds which may have been spent incorrectly may now be spent on those whose need is greatest.

Question: What is the status of State programs designed to ascertain third-party liability on Medicaid claims and recover appropriate amounts?

Answer: In their efforts to make the best possible use of monies available to them, States have identified TPL as an effective means of reducing erroneous expenditures. Consequently, they are increasing activity in the identification and pursuit of liable third parties.

Five major types of third party liability resources form the hub of State agency TPL activity. According to existing levels of TPL recovery, these resources are private health insurance, government programs (Medicare, CHAMPUS and CHAMPVA), liability and casualty insurance (automobile insurance, Workman's Compensation, etc.), probate, and IV-D and paternity child support obligations.

Sophisticated TPL pre-payment cost avoidance systems (i.e., referring claims to third parties before Medicaid funds are used) have been developed in States with both large Medicaid populations (Pennsylvania) and small recipient populations (Minnesota). Cost avoidance is best suited for claims involving health insurance coverages, no-fault automobile insurance coverages, government health insurance benefits and IV-D resources. Other States (Wisconsin) rely heavily on benefit recovery systems (i.e., recouping monies which have already been expended). In such States, the procedures and functional lay-outs for more effective collections from liable third parties are being extensively defined and implemented. The benefit recovery program is particularly useful in handling liability/casualty claims, probate claims, Workman's Compensation claims and other intractable or time-consuming cases.

Most State TPL programs involve a combination of both the cost-avoidance and benefit-recovery systems. A combination of both approaches allows flexibility in the review and recovery of reimbursement from TPL resources. Both cost-avoidance and benefit-recovery systems are dependent upon the identification of liable third parties. Consequently, programs are being initiated to assure that IV-A (AFDC) and Medicaid workers gather TPL information during the eligibility and redetermination processes.

Efforts to obtain enabling legislation have begun to play a major role in the activities of HCFA and the States. Federal legislation (PL 95-142) has recently been promulgated to facilitate State efforts in the pursuit of health insurance coverage provided by absent parents for their Medicaid eligible children. In addition, many States are actively pursuing legislation which supplements Federal regulations in a number of third party liability areas, and which will permit more effective implementation of TPL programs. Laws requiring assignment of rights and subrogation for Medicaid recipients are pending in a number of States. Laws which prevent private insurance carriers from writing contracts which terminate or restrict coverage if an individual is found eligible for Medicaid, and which authorize estate recoveries have been passed in Minnesota and Maryland, respectively.

Throughout State Medicaid jurisdictions, TPL programs differ widely in range and scope and in levels of effectiveness.

In general, the effectiveness of State Medicaid TPL programs correlates highly with the budget allowed the programs by State legislatures. Since States are permitted to determine the size of their TPL program with respect to personnel and the degree of automation involved in Medicaid claims processing, a substantial part of a TPL program's success is related to adequate funding of administrative costs.

Several other variables also determine the difficulty and amount of recovery or avoidance of Medicaid benefits by a TPL program. They include:

- The size of the TPL recovery/avoidance unit

- The degree of automation involved in the claims analysis and tracking process of Medicaid invoices.

- The type of system used to process claims.
- The size of a State's Medicaid population.
- The extent of the resources available for TPL review, a State's legal structure, and past levels of insurer cooperation.

Question: How effective have these programs been?

Answer: A State's allocation of staff and budget for the recovery and avoidance of Medicaid benefits ultimately determines the level of Medicaid expenditures which can be reduced through the TPL program. In addition, the initial implementation costs are directly related to the level of sophistication of the Medicaid data processing system already in place.

Several other aspects of State Medicaid programs influence cost-recovery ratios. These factors are: (a) the number of employers and other group health plans with extensive medical benefits in the State; (b) the percentage of the Medicaid population which engages in part-time work; (c) the auto insurance laws of a State (in 1979, 36 percent of the States did not require automobile liability insurance after the first accident); (d) the Workman's Compensation laws in a State, and (e) judicial support in establishing paternity and Medicaid liability in IV-D absent parent cases. Therefore, a strict comparison of expenditures for a TPL program against returns on reduced Medicaid costs is impossible, due to exogenous factors influencing both the costs of operating a TPL program and the levels of cost-avoidance and benefit-recovery. Similarly, the effectiveness of an automated identification, tracking and monitoring system depends heavily on the data base available, and the expertise of TPL unit personnel.

A recent survey, however, does identify some average ratios of TPL recoveries to administrative costs by resource type. Based on State calculations, the least cost-effective resource was paternity cases in which a TPL program could expect to recover four dollars for each dollar allocated. The most cost-effective resources proved to be no-fault auto insurance (12:1) and probate claims (10:1). However, health insurance (9:0), the easiest TPL resources to automate for either cost-avoidance or benefit-recovery, produced the highest average amount collected - $3.61 million per year - and, therefore, represents the greatest potential dollar recovery resource.

Question: How much money has been recovered?

Answer: Total Third Party Liability collections as reported by the States on the HCFA 64.9b for fiscal year 1980 are $67,997,916. The fiscal year 1980 share of collections attributable to Medicare total $18,306,018. Thus a net figure of $49,691,898 for Medicaid collections have been recovered for fiscal year 1980.

EARLY & PERIODIC SCREENING, DIAGNOSIS, & TREATMENT (EPSDT)

Question: Why have the States failed to identify eligible children under the EPSDT program?

Answer: The EPSDT program is a radical departure from the traditional Medicaid program or welfare medicine.

Initially, States had problems in adjusting to the concept of prevention, which had been a low priority item in the past. To some extent, outreach and promotion of clients conflicted with cost containment concerns. Additionally, program managers were unfamiliar with arranging for delivery of health care covering entire categories of services (screening, diagnosis, and treatment).

In spite of early difficulties, States are improving outreach efforts through community and media campaigns, focused staffs, and interagency linkages. These efforts to increase the number of eligible children identified are coupled with improved automated methods of case tracking and provider billing.

Question: Have penalties been assessed to States not complying with EPSDT requirements under the penalty provision enacted in 1972 which reduced a State's AFDC grant by 1 percent each quarter the State did not comply?

Answer: Although the EPSDT penalty regulations became effective on 10/1/79 and the initial reviews of State compliance took place in July-September 1980, no penalties have been assessed to date. However, the purpose of EPSDT monitoring is not to assess penalties but to improve program performance and the health of eligible children.

The EPSDT program employs a phased approach to monitoring, beginning with an assessment of State performance according to norms and criteria as part of annual management reviews. If problems are identified as a result of the assessment, specific corrective action strategies are put in place, and those States which appear to be unwilling or unable to meet these minimum criteria are subjected to more intense review and frequent consultation.

Question: What efforts have States made to comply?

Answer: The issued requirements of the EPSDT regulation (i.e., to inform beneficiaries of the availability of services and to provide those services in a timely fashion) have resulted in increased attention to their EPSDT programs.

For instance, increasing numbers of States are enhancing outreach through community campaigns and linkages. Automated client tracking and billing systems are being developed, and more comprehensive care providers are participating.

We are providing technical assistance, both directly and through contracts, to aid States in developing the capacity to provide better case management and to establish information systems for EPSDT. We are currently developing an EPSDT component for the Medicaid Management Information System (MMIS).

Additionally, we are encouraging States to open their EPSDT programs to comprehensive, continuing care providers. In some States this requires a significant reorientation of those EPSDT operations which developed largely as public screening clinics using private practice physicians as referral providers only.

Initially, States expressed concern with documentation requirements to provide a sampling base for penalty monitoring, but through subsequent modifications these requirements have since been significantly reduced.

Question: What other efforts has the Federal Government made to ensure State compliance?

Answer: A HCFA initiative has been established for EPSDT, the primary objective of which is to implement the Department's child health strategy through several means, including effective implementation of Title V-Title XIX agreements, and the use of Public Health Service (PHS) grantees such as community health centers, as well as Title V primary care projects as EPSDT providers.

Additionally, an EPSDT Technical Advisory Group (TAG) composed of State Medicaid and EPSDT officials has been established to advise HCFA on all aspects of the program, and will participate in the "sunset review" of the EPSDT regulation.

Along with these efforts, an annual performance-oriented State EPSDT/Medicaid child health action planning process is being developed. Plans will be required linking documents setting forth specific objectives and action steps, and serving as the basis for State, regional, and national program assessment.

Also, specific criteria for State program assessments are being defined. We expect that assessment findings will trigger corrective actions and/or technical assistance activities. Further assessments will identify States which are potentially liable for penalties.

Question: How many providers participate in the EPSDT program as opposed to providers in the entire Medicaid program?

Answer: At the present time, there are no reliable statistics to answer this question because although specific provider agreements for EPSDT services are encouraged, all qualified Medicaid providers are eligible to participate. Similarly, EPSDT services are provided in a variety of ways, such as by physicians in individual or group practice settings, by nurse practitioners, by health department and by hospital outpatient clinics, etc.

However, some child health relationships within Medicaid can be discerned based on the fact that children have accounted for 30 percent of Medicaid expenditures for physicians services; 28 percent of Medicaid expenditures for outpatient hospital services; and 21 percent of Medicaid expenditures for inpatient hospital services.

Question: How have States met requirements of EPSDT if there is a lack of providers in a particular State?

Answer: Through coordinated planning at the federal level, we are assisting States in increasing the number of providers. In order to maximize scarce resources and minimize duplication, a joint HCFA-PHS child health strategy has been developed and is assisting States to extend services to more poor children. The focal point of this strategy is to ensure that Medicaid makes maximum use of PHS-supported facilities, including Title V projects and community health centers, as EPSDT providers. There is, in fact, a common HCFA-PHS management objective at the Regional level that 80 percent of such centers become EPSDT providers by the end of FY 1981.

Other efforts to maximize resources include joint HUD-EPSDT initiatives serving to improve delivery of services to eligible children in public housing settings and joint HCFA-Education-PHS initiatives using school districts to promote and extend EPSDT. Additionally, Head Start refers all Medicaid-eligible enrollees and siblings to EPSDT providers for their required health assessments and necessary follow-through.

We have found that the use of Medicaid dollars has enabled PHS and Office of Human Development Services (OHDS) resources to serve more low income children, particularly those not eligible for Medicaid.

States have also responded to the problem by transporting services to clients via mobile units as well as by transporting clients to health care resources.

Question: To what extent have there been documented cases of fraud in this program?

Answer: There have been no documented cases of fraud in the EPSDT program. In fact, fraud in any preventive program is rare.

One major concern is underutilization, since EPSDT's emphasis on prevention and primary care is the essence of cost containment.

For instance, studies have shown savings of 40 percent in health care costs for children who received EPSDT preventive services. In one study, the Community Health Foundation in North Dakota found that the EPSDT screened and referred children used 21-39 percent fewer inpatient hospital services and incurred 36-44 percent lower per capita expenditures (47-58 percent lower hospital costs) than children not participating in EPSDT. In a second study, Portsmouth, Virginia AFDC recipients using the EPSDT package had total Medicaid costs 1/3 less than recipients using Medicaid EPSDT services.

ESTIMATE FOR MEDICAID

Medicaid vendor payments increased by 17.8 percent in 1980: and are projected to increase by 16.1 percent in 1981 and 12.1 percent in 1982.

Question: Why are the 1982 estimated increases so far below recent actual experience?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: Isn't it likely that Medicaid outlays will run between $600 million to $800 million higher than the Carter budget estimates if past history repeats itself?

Answer: Since the budget estimating process has been modified to be based on State estimates, the anticipated variance between the estimated outlays and actual outlays has been reduced. The historical variance for State estimates is approximately 2 percent.

HOSPITALS PAYING WIDELY DIFFERENT PRICES FOR COMPARABLE SUPPLY ITEMS

In a January 1980 report, the GAO reported that hospitals were paying widely different prices for comparable supply items and there appeared to be no reason for this. To address this problem, GAO recommended that price information be disseminated to hospitals. With pricing information in hand, GAO felt that hospitals would be in a better position to negotiate with suppliers and thereby reduce wide price variances.

Question: What has the Department done in response to the GAO recommendation?

Answer: The Department of Health and Human Services feels a cautious approach to the General Accounting Office's (GAO) proposed solution to the problem of varying prices for routine supplies is appropriate and that a limited operational project which implements GAO's recommendations should be undertaken before national implementation is attempted. Accordingly, we proposed to initiate a pilot test of GAO's approach at two intermediary sites. The Secretary has approved the action.

We investigated potential test sites where both the intermediary and the hospital association would agree to voluntary participation. We have found that the support of the local hospital association is essential in obtaining voluntary participation of the hospitals. We have completed site visits to Maryland, Connecticut, North Carolina, and Florida. The Maryland and Connecticut Hospital Associations declined to participate. Participation of North Carolina and Florida appears favorable, however, legal issues involving restraint of trade, liability, and hospital anonymity have so far precluded us from reaching formal agreements. An opinion on the legal issues was obtained recently from the Office of General Counsel and relayed to the sites. We are now awaiting their decision to meet and proceed with the project.

Should the legal issues be resolved to the satisfaction of all parties, we hope to reach formal agreements shortly. The sites have been supplied with copies of the proposed project description and the tentative list of supply items to be monitored. They are also being notified that fiscal year 1981 funding of the project has been approved.

Question: What savings have been or are likely to be realized?

Answer: The purpose of the project is to determine the cost-effectiveness of a price monitoring and information exchange system. Cost savings will be determined by evaluation of the project in its completion.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, NONHOSPITAL ACTIVITIES

Question: What is the Department doing to implement the requirement of the Reconciliation Act that the Secretary establish a program for evaluating the cost effectiveness of PSRO review of Long-Term Care and Ambulatory services?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What is the anticipated scope of this program?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What will be your main area of focus in the coming year?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: What is the estimated cost of the evaluation program?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: What is the status of PSRO review in long term care facilities?

Answer: In FY 1980, $11.0 million was allocated to long term care review and 55 PSROs were funded. Depending on a final FY 1981 budget resolution, long term care projects will be reduced or eliminated.

Question: What impact have such reviews had on service delivery patterns and costs?

Answer: Significant gaps in quality of care provided to nursing home patients (e.g., missed diagnoses, improper drug use, and inadequate physician attention) have been identified by PSROs and brought to the attention of long term care providers. While exact cost savings information is not available, it is reasonable to assume that through preadmission reviews, which potentially eliminate unnecessary institutionalization when alternative placement is available, savings have occurred.

LONG TERM CARE REVIEW

Question: How many existing long term care facility projects are expected to be continued under the evaluation program mandated by P.L. 96-499?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

(CLERK'S NOTE.--The following is the administration's response to those questions in the record that were under review by the Secretary at the time of the Department's submission of its earlier responses.)

Question: Why are the FY 1982 estimated increases so far below recent actual experience?

Answer: The current law Medicaid vendor payments increased by approximately 11 percent between FY 1981 and FY 1982. The estimates equal the aggregate of the States' estimates for their FY 1982 expenditures. The lower rate of increase reflects the States' plans to control their costs as well as the expectation of reduced State resources.

The Administration has also proposed legislation to CAP the entire Medicare program beginning in FY 1981. The proposal would limit the increase between FY 1981 and FY 1982 to a 5 percent increase.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, NONHOSPITAL ACTIVITIES

Question: What is the Department doing to implement the requirement of the Reconciliation Act that the Secretary establish a program for evaluating the cost effectiveness of PSRO review of long term care and ambulatory services?

Answer: Due to the scheduled phasedown of PSROs, the Administration is proposing legislation to ultimately discontinue Federal support for PSROs. The cost effectiveness of PSRO review of long term or ambulatory care is not a program focus, given the phasedown. A small amount of long term care will be funded in FY 82, with neither ambulatory nor long term care funded in FY 83. With these proposed changes, the need to develop a cost effectiveness evaluation scheme is moot.

Question: What is the anticipated scope of this program?

Answer: Since the timing of enactment of this provision was so near the change of administration, the anticipated scope of this cost effectiveness study was never specifically determined.

Question: What will be your main area of focus in the coming year?

Answer: While awaiting the outcome of budgetary and legislative action on the future of PSROs, full scale staff work on the projects will not take place.

Question: What is the estimated cost of the evaluation program?

Answer: Since the research design has not yet been determined, no cost estimates are presently available.

LONG TERM CARE REVIEW

Question: How many existing long term care facility projects are expected to be continued under the evaluation program mandated by P. L. 96-499?

Extensive work is not planned in this area since HCFA is proposing legislation both to facilitate termination of PSROs and to repeal the evaluation program requirements of Section 924 of P. L. 96-499.

CALIFORNIA REQUEST FOR REVIEW OF PSRO PROGRAM

Question: The California State Department of Health Services has written at least twice to HCFA to suggest a joint study of the relative impacts of different utilization review (UR) systems on the cost and quality of health care. Why has HCFA refused to participate in such a study and what efforts is HCFA making to encourage the development of alternate forms of UR as possible replacements for PSRO review?

Answer: The proposal by the California State Department of Health Services seeks HCFA cooperation in a study of the impact of PSRO performance. Our main emphasis in the evaluation of the PSRO program has been the annual PSRO evaluation by the Office of Research, Demonstrations, and Statistics. Given the extent of controversy surrounding the HCFA and CBO program evaluations, we have been hesitant to embark on other approaches to evaluating PSROs. With our initiatives to give States more flexibility under the Medicaid cap, and to phase down PSROs, it is not likely that the study will be undertaken.

REDUCING MEDICAID COST

Question: It has been suggested that the most effective way to reduce the cost of an entitlement such as Medicaid is to either reduce benefits or restrict eligibility for the program. Is there a sensible way to restrict eligibility for the Medicaid program, so that program costs can be contained, but essential services will not be denied to the needy?

Answer: We are proposing a number of statutory changes in the manner in which eligibility is determined and the types of persons who should be eligible for cash assistance programs. These reforms will ensure that cash assistance is more effectively targeted to those persons in greatest need of such assistance. Medicaid eligibility derives from eligibility for the Aid to Families with Dependent Children and Supplemental Security Income cash assistance programs. More appropriate targeting of these programs, therefore, will ensure that Medicaid benefits are also provided to the neediest populations.

In addition, we are proposing that States be given greater flexibility in choosing which other persons should be eligible for Medicaid benefits. Since States have different populations, different needs, and different financial capabilities, it is appropriate that these eligibility decisions be made at the State level.

WELFARE DEMONSTRATIONS

Senator Inouye: The Committee would appreciate learning from the HCFA of its plans to implement the AFDC Welfare Demonstration project that was authorized in the Omnibus Reconciliation Act of 1980, Public Law 96-499. The Committee understands that the Congressional Budget Office has estimated that this particular provison will result in savings of $44 million by the end of its second year and, accordingly, the Committee wants to make sure that it is implemented in a timely and expeditious fashion.

Answer: The Department is very supportive of the concept of making employment opportunities available to mothers receiving AFDC payments. In this context, we have reviewed the provision in the Reconciliation Bill mandating the AFDC demonstration project. At this time, we are examining in detail alternative ways of funding this provision to determine which approach would be most appropriate. A final decision on the implementation of this provision, therefore, is expected very soon.

FINANCIALLY DISTRESSED HOSPITALS

Question: What initiatives is HCFA planning to help prevent the closure of Financially Distressed Hospitals?

Answer: No addititional inititatives are planned for FY 1982. HCFA will concentrate its resources on the existing two FY 1980 demonstrations in New York and three FY 1981 awarded demonstrations in Florida, Massachusetts and California. The findings from these studies will suggest innovative policy directions for delivery of primary care, alternative reimbursement techniques, improved management information systems and different Medicaid eligibility criteria. Any further decisions to resolicit or expand these projects will be predicated upon the results of the existing sites.

Question: What steps are being taken to help assure that more and more hospitals do not face severe financial difficulties?

Answer: The results from the current projects will yield valuable insights into such cost avoidance measures as a case management system of health professionals assuming the role of "family doctor" responsible for the health care of a group of enrollees. This may lead to better health care as well as the use of more cost-effective services. The projects will permit comparison of current Medicaid reimbursement with a capitation approach to case management. Improved bill collection and tracking will be implemented to determine the effect of hospital management improvements on a hospital's financial viability. In the area of eligibility changes, the projects will enable HHS to determine demographic composition and health costs of the currently uninsured populations.

MEDICARE CONTRACTING

Question: By what date might HCFA be sure enough of the fixed-price contracting concept to attempt it on a nation-wide basis?

Answer: The decision to move forward will depend upon favorable legislation. Experience to date would indicate steps can be initiated on a selected basis.

MEDICARE CONTRACTORS

Question: Are you now prepared to seek legislative authority to permit selection of Medicare contractors competitively on a permanent, rather than experimental basis?

Answer: The exact timing of seeking legislative authority to permit selection of Medicare contractors competively on a permanent, rather experimental basis, is still being considered within HHS.

SUBCOMMITTEE RECESS

Senator SCHMITT. The subcommittee will stand in recess until 2 p.m. tomorrow when we will meet again in this room to hear appropriation requests for the Health and Human Services Department of Management and other items.

The hearing is recessed.

[Whereupon, at 12:35 p.m., Tuesday, February 24, the subcommittee was recessed, to reconvene at 2 p.m., Wednesday, February 25.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

WEDNESDAY, FEBRUARY 25, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2:05 p.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Arlen Specter presiding.

Present: Senator Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MANAGEMENT AND BUDGET

STATEMENT OF MS. ALAIR A. TOWNSEND, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET

ACCOMPANIED BY:

PAUL R. KRETCHMAR, ACTING DIRECTOR, OFFICE FOR CIVIL RIGHTS
BRYAN B. MITCHELL, ACTING INSPECTOR GENERAL
GERALD H. BRITTEN, ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY FOR BUDGET
JOHN P. SCULLY, DIRECTOR, DIVISION OF OFFICE OF THE SECRETARY, BUDGET SERVICES

SUBCOMMITTEE PROCEDURE

Senator SPECTER. Good afternoon, this afternoon we are scheduled to hear the budget request for the management side in the Department of Health and Human Services.

I'm advised that this Department is one of the biggest in the Federal Government, having the permanent staff of more than 140,000 and the budget which exceeds $200 billion. The job of running this organization is obviously a large and complex one, and scheduled today to speak for the HHS departmental management budget is Assistant Secretary for Management and Budget, Alair Townsend.

PREPARED STATEMENT

Ms. Townsend, we welcome you, and we would appreciate if you would start by introducing your colleagues and then, in accordance with our committee procedure, we would appreciate it if you would synopsize in relatively brief form your prepared statement, since your statement will be made a part of the record.

[The statement follows:]

STATEMENT OF MS. ALAIR A. TOWNSEND

I am pleased to be with you today to discuss the activities supported by the General Departmental Management appropriation of the Department of Health and Human Services.

The General Departmental Management appropriation supports two basic categories of activities: departmental direction, which provides the administrative staff to fulfill the Secretary's responsibilities as policy officer and general departmental manager; and departmental operations, which includes those specialized services staff that perform centrally those functions that lend themselves to economies of scale.

The second Continuing Resolution of fiscal year 1981 authorizes 3,934 positions with which to carry out these two categories of activities. Since the fiscal year 1982 appropriations request as developed by the current Administration, is not yet available for discussion, I shall summarize briefly for you the programmatic and functional elements that are included in the 1981 Continuing Resolution.

Departmental Direction

Departmental direction is made up of executive direction, public information, management and budget, personnel administration, field management and the general counsel activities. These elements are staffed in fiscal year 1981 with 1,404 positions. Through the efforts of these people, the Department's 145,000 authorized staff receive overall direction and management, including financial management, budget formulation, personnel management, grants and procurement management, policy analysis, and legal services.

Departmental Operations

Departmental operations is the service element of General Departmental Management. Authorized in fiscal year 1981 at 2,530 positions, this activity is comprised of facilities engineering, administrative services, grants payment system, regional services, legal services, and the employee systems center activities. The magnitude of the workloads performed by these people can be readily conceptualized by considering a few specific numerical indicators:

- The office of facilities engineering, with an authorized staff of 265 positions, provides reviews of technical design and architectural/engineering-related guidance to grantees on 963 federally assisted construction projects with estimated values of $4.9 billion.

- The grants payment system, with an authorized staff of 47 positions, reviews 44,000 quarterly grant recipient reports of expenditures and cash accountability covering over $30 billion in grants.

- The regional services activity, with 1,287 authorized positions, services over 94,000 employees including processing personnel actions, vacancy announcements, adverse actions and grievances.

o The employee systems center staff of 239 authorized positions processes approximately 155,000 time and attendance documents and 35,000 personnel transactions 26 times a year.

In addition to these general descriptive comments, I would like to highlight one area of concentrated effort by the Office of the Secretary--financial management and control of Federal funds.

The general objective is to disperse funds to grantees as close in time as possible to when they are actually paying bills. This reduces Federal interest costs and prevents excess cash from building up in grantees' bank accounts and earning interest for them.

We are assuming greater control over Federal funds in stages, with respect to both the number of grantees and programs covered and the type of controls we are imposing.

The Department has been implementing first a delay-of-drawdown letter of credit procedure, followed later by implementation of a checks-paid letter of credit procedure where determined cost-effective in a State. The objective of both procedures, as I noted earlier, is to delay the transfer of Federal funds to a State until the day when disbursement checks or warrants issued by the State have cleared the State's bank account. The delay in transferring Federal funds results in significant outlay savings and interest savings to the Federal government.

The delay-of-drawdown procedure is simpler to implement but less reliable than the checks-paid procedure because it relies on estimating techniques by the State for determining when a Federal cash draw should be initiated. The checks-paid procedure is technologically more complex to implement and has greater impact on State systems because it relies on actual encoding of the Federal dollar portion on the State's check or warrant to enable the bank to tally the Federal portion of the checks clearing daily and make the draw of Federal funds. The checks-paid procedure is superior because, once implemented, the procedure operates automatically and is not subject to estimating errors or manipulation.

The checks-paid procedure will be installed where it either is not excessively costly to implement or where it will produce significant additional savings above the savings being achieved under the delay-of-drawdown method.

Delay-of-drawdown procedures were implemented in 7 States in 1980. These procedures are being implemented in an additional 20 States in 1981. The current initiative is limited to our largest programs, the direct assistance activities of the public assistance programs. It is our intention to cover additional States and programs over time.

These new financing methods produced one-time outlay savings of $262 million in 1980 and are expected to produce additional one-time outlay savings of $150 million in 1981. The outlay savings, when achieved, begin immediately to yield interest savings to the Federal government. The combined outlay savings for the two years will yield estimated recurring annual interest savings of about $38 million based on a Treasury interest rate of 9.15 percent.

Regulatory Budget

The principal regulatory role of Departmental Management is in regulations development. The Immediate Office of the Secretary, the Office of the Assistant Secretary for Planning and Evaluation, the Office of the General Counsel, and, to a lesser degree, other staff offices advise the Secretary on each regulation promulgated. General Counsel staff also perform legal drafting services for all regulations. The fiscal year 1981 Second Continuing Resolution contains 56 positions to perform this function, 52 of which are located in the Office of the General Counsel. In addition, 10 staff years of effort are provided by Office of the Secretary staff assigned in particular substantive areas of responsibility who comment upon agency draft regulations shortly before Secretarial decisions. We estimate that a total of 66 staff years are devoted to such oversight and drafting assistance.

A secondary role, but one consuming far more staff resources, arises in litigation. In the Office of the General Counsel 490 staff support the Department's litigation workload, concentrating on efforts to defend the Department's activities and regulations promulgated pursuant to statutes, such as disallowances in funds claimed for reimbursement by grantees.

Finally, the Office of the Assistant Secretary for Management and Budget issues and enforces regulations. The Office of Grants and Procurement has responsibility for developing and enforcing grant and procurement regulations department-wide. This office has 67 positions; two-thirds, or 44 positions, are devoted to these activities. In addition, the Office of Facilities Engineering devotes 3 positions to development and enforcement of standards for federally-assisted facilities construction.

In conclusion Mr. Chairman, I appreciate the opportunity to outline the functions supported by the General Departmental Management appropriation and will be pleased to respond to any questions you or the Committee members might have.

I am pleased to appear before you today to provide a brief synopsis of the activities of the Office of Inspector General. During almost four years of operations, the Office of Inspector General has enjoyed the strong support of your Committee. As a result, I believe we have made substantial contributions to the Department's progress toward reducing fraud, abuse and waste in the programs administered by the Department of Health and Human Services.

ONGOING ACTIVITIES

I will discuss our activity as presently organized into Executive Direction/Management and three operating areas.

Executive Management, which has a budget authorization of 27 positions, includes the Inspector General, the Deputy Inspector General, plus a support staff directed by an Executive Assistant Inspector General. The support staff provides a wide variety of administrative services to both headquarters and field staff.

There are three operating units of the Office of Inspector General. The first one is the Audit Agency. It is our largest organization, having an authorized budget of 750 positions. In FY 1980, the Audit Agency issued 5,293 audit reports, as compared to 4,706 in FY 1979, an increase of 13 percent.

These reports resulted in $123.8 million in audit-recommended financial adjustments which were entered into the departmental accounting system as accounts receivable. Another $19.7 million in savings occured as documented cost avoidance resulting from audit recommendations. In FY 1981, the Audit Agency is committed to achieving a savings goal of $134.0 million in accepted audit-recommended financial adjustments. We are proud of these efforts. Through recommended financial adjustments, the OIG audit function recovers, by a multiple of three, the cost of all OIG operations. To enhance these efforts, we use contractual authority to supplement our staff with contractual audits conducted by private accounting firms.

The second operating unit is our Office of Investigations (OI). This office was originally formed as a small centralized unit in 1975. It now has an authorized budget of 187 positions with agents housed in 30 cities throughout the country. The Office of Investigations has responsibility for directing the investigation of all criminal activities in connection with HHS programs and for liaison with outside agencies regarding these matters. Currently, OI's workload consists of 2,721 formally opened cases and preliminary investigations. During FY 1980, the Office of Investigations activities resulted in: 141 indictments; 117 convictions; and fines, recoveries, and restitutions of close to $11 million. We are looking to increased results in future operations.

In addition to our direct investigative responsibility, the Office of Inspector General has a division charged with the responsibility for oversight and coordination of the State Medicaid Fraud Control Units. Thirty (30) States presently have fraud units in operation, and it is anticipated that eleven (11) additional States will establish units and seek funds to initiate their functioning.

This division has initiated many actions to improve the quality and quantity of medicaid fraud investigations and prosecutions. The timely responsiveness of the division to fraud unit problems has been a major factor in helping the units to deter fraud in the medicaid program, and ultimately to help provide better health care for those who are not financially able to do so for themselves.

Our immediate goal is to further improve the quality of the State Fraud Units by adopting policies which ensure high quality staffing for the units and allow units more control in the investigation of medicaid fraud, such as contracting for professional services in particularly massive cases, and contracting for special computer services to enhance their fraud investigations without duplicating the State Medicaid Agency's responsibilities. We continue to encourage State training conferences so that lessons learned can be shared by all units.

REGULATORY RESPONSIBILITY

The responsibility for administering the grants to State Medicaid Fraud Control Units entails a review of applicable regulations and consideration of possible amendments to these regulations, such as specifying eligibility requirements and funding limitations. This has entailed a half-person year in the last year, at a cost of approximately $15,000 per year. The regulations impact on State grantees, and there is no further regulatory cost.

Our third operating unit is the Office of Health Care and Systems Review (HCSR), which has an authorization of 36 positions. This office is the principal research, planning and systems analysis arm of the Office of Inspector General. It is staffed with a group of senior experts in program areas, management systems, and State agency operations. This flexible group is called on to coordinate the conduct of major ongoing activities and in special projects; to conduct systems analyses and to perform Service Delivery Assessments (SDA) and studies which provide the Secretary with a grass-roots program performance review.

Among the studies produced by this staff was an examination of the debt collection practices of the Public Health Services (PHS). PHS operates a number of student and institutional loan programs. As a result of the HCSR findings, the Under Secretary directed a "stepped-up" program to collect outstanding debts and to prevent serious backlogs of uncollected debts from occurring.

That concludes my statement, Mr. Chairman. I will be happy to answer any questions from you and the Committee.

I appreciate the opportunity to testify on the civil rights enforcement responsibilities of the Office for Civil Rights.

Compliance Responsibility

The Office for Civil Rights (OCR) is the principal agency responsible for enforcing the nondiscrimination laws in health and human services programs. Approximately 93 million persons participate in these federally assisted programs and thus are protected against discrimination on grounds of race, color, national origin, handicap, and age. There are about 740,000 recipients of Department funds subject to the civil rights laws. OCR's responsibility is to ensure that all providers are aware of their civil rights obligations and have taken the necessary steps to comply.

In addition, as of December 8, 1980, OCR was delegated the responsibility to enforce the community service assurance undertaken by hospitals and other facilities that received funds under Title VI or Title XVI of the Public Health Service Act. This provision obligates such facilities to make health care services available to all persons residing in the service area without discrimination on grounds of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service.

To enforce the nondiscrimination statutes, OCR conducts compliance reviews, investigates discrimination complaints filed by citizens, and provides technical assistance so that providers will be able to comply with the law on a voluntary basis.

Complaint Investigations

Under the implementing regulations OCR is committed to address each citizen complaint of discrimination in a timely manner. In addition, in recent cases the Federal courts have held that compliance agencies are obligated to take action when information indicating possible noncompliance with the civil rights laws is submitted. Finally, the Department of Justice, which coordinates civil rights enforcement governmentwide, requires each compliance agency such as OCR to promptly resolve complaints alleging race, color, or national origin discrimination in federally assisted programs.

Since 1976, the number of complaints filed has increased annually from 400 complaints to 1,776 new complaints in FY 1980.

Complaints vary considerably in regard to the allegations raised and hence the amount of investigative time expended. About 50 percent of the complaints allege discrimination on the basis of handicap. Here the complaints range from the alleged failure of a provider to assure accessibility, to employment cases where a provider reportedly did not take steps to reasonably accommodate an employee's handicap. Other complaint cases typically focus on such issues as differential treatment in regard to admissions, referral practices, and the provision of services.

Compliance Reviews

Department of Justice guidelines require compliance agencies such as OCR to establish an effective program of field compliance reviews targeted at a representative number of major grant recipients. Under regulations implementing the nondiscrimination statutes OCR is committed to periodically review the practices of recipients. In addition, in a recent report to Congress, the General Accounting Office recommended that OCR allocate "sufficient staff to permit timely reviews of Title VI compliance." Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in federally assisted programs and activities.

Hence, OCR has conducted compliance reviews as part of the enforcement effort. Unlike most complaint investigations, reviews usually focus on relatively large recipients or health care systems and cover a broader range of issues. Hence their impact is more significant and far-reaching in terms of correcting practices that have the effect of discriminating against large groups of beneficiaries.

Discrimination complaints, survey data and other information point to numerous critical issues that will receive priority attention. Some of these topics are: admission practices and accessibility of hospitals, nursing homes, and extended care facilities to minorities and handicapped persons; child welfare referral and placement practices; provision of services to minority applicants and clients with regard to eligibility and access to social services; the responsibility of health planning agencies to assure equal access to services for minorities, the elderly, and other medically underserved groups; and accessibility of health care and social services to handicapped persons.

Technical Assistance

Since 1978 OCR has administered a technical assistance program as an integral part of the enforcement effort. Through technical assistance OCR is able to encourage voluntary compliance on a wide scale by making compliance information available to thousands of health care and social service providers that request and need guidance. Institutions have a right to know how to interpret and apply the nondiscrimination requirements to particular programs and beneficiaries in the most effective manner. OCR's technical assistance program is designed to meet this need.

Technical assistance is a cost-effective strategy that has helped reduce the potential costs of making programs accessible to handicapped persons. In addition, OCR relies on technical assistance to help remedy compliance problems.

Mainly through contracts OCR has provided staff training to 4,500 representatives of health care and human services providers on how to comply with Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of handicap. In all OCR expects to reach approximately 14,000 individual providers through staff training programs. We are also developing a model compliance plan for medium-sized community hospitals which will include training of hospital staff in the techniques of achieving compliance with Section 504 in a cost-effective way. As a result of one training project, 519 recipients in seven states took steps to comply with Section 504 requirements. Approximately 400,000 copies of manuals and handbooks describing nondiscrimination standards will be distributed as those materials are developed in FY 1981.

Technical assistance is also provided directly, on request, to recipients of Department funds, beneficiaries, and state and local officials. Staff in some regional offices provide assistance by conducting on-site visits, distributing information, participating in training conferences, and responding to inquiries.

Legal and Support Services

OCR relies on the Civil Rights Division of the General Counsel's Office for legal assistance in processing the investigative casework. Such assistance is essential to ensure that investigative findings are legally sound and consistent with evidentiary standards and court decisions.

Regulation Enforcement

All appropriated funds and positions authorized to OCR are provided to secure compliance with the nondiscrimination laws and implementing regulations. Costs to the agency are incurred in developing, promulgating, and enforcing the nondiscrimination regulations and in providing technical assistance.

The major regulations OCR enforces are those implementing Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin, and Section 504 of the Rehabilitation Act. The Title VI regulation was promulgated in 1965 and revised in 1973. No regulatory analysis was prepared at that time.

The Section 504 regulation took effect on June 3, 1977. An exploratory study, completed in 1979, estimated that in the health care and social services area the one-time costs of making programs accessible to handicapped persons would total between $208 million and $241 million. In addition, one-time costs for auxiliary aids were estimated to be $14 million. The study also estimated that the recurring costs of meeting the program accessibility standard and of acquiring auxiliary aids would fall in the range of $23 million - $34 million annually. It should be pointed out, however that the estimates were made before recipients benefited from largescale technical assistance from OCR.

Under the Age Discrimination Act the Department is required to review the final regulations developed by other departments and agencies to implement the Act. When the Department published a general regulation containing guidelines for agencies to follow in developing their regulations, a preliminary estimate was made that one-time non-Federal costs of complying with regulatory requirements would amount to $16 million - $18 million. However, the major cost factor involved the conduct of a self-evaluation; this procedure is still under review. Recurring non-Federal costs were estimated to be $1 million - $9 million. These costs would arise in connection with agency enforcement activity.

The total cost figures cited here affect an extremely large universe of departmental grantees and subgrantees. Few recipients will face costs that are substantial in comparison with their individual budgets.

This concludes our statement on the activities of the Office for Civil Rights. We will be happy to answer any questions you may have about the program.

Thank you.

I am here today to discuss Policy Research activities authorized under Section 1110 of the Social Security Act.

General Purpose

The Policy Research Program administered by my office provides the Federal Government with one of its most important sources of research and data used in the development of social policy in the United States. The Program's objective is to develop basic information on the income sources and characteristics of the low income population; on the impact of existing and proposed programs on that population; and on the other issues that cut across HHS agency lines. It is the only research program that provides the Department with the flexibility to examine issues of national policy significance cutting across program, subject and agency lines; and to study policy alternatives before they are actually operating under law. This kind of research can be targeted at a range of policy relevant issues rather than at predetermined policy choices and thus is invaluable in its capacity to provide basic analytic information that can be used by the Department and other policy leaders in the Executive and Legislative Branches to evaluate a range of alternatives in the development of national policy.

Much of the data and cost estimating capability used by the Department in developing program reform proposals derives directly from the Policy Research Program. Policy Research supports a series of modeling efforts that enable us to estimate the cost, caseload, distributional and other effects of various tax, transfer and service delivery options. These data models allow much more comprehensive analyses of policy options and facilitate rapid responses to inquiries and requests.

I would like, now, to discuss the achievements of several major experimental and developmental Policy Research activities.

The Seattle-Denver Income Maintenance Experiment is a 10 year large-scale field project designed to measure the effects of welfare payments on the work effort of recipients and of manpower training subsidies on the earnings and employability of low-wage workers. The experimental and analytic work in this project has been completed, and current efforts are devoted largely to completing preparation of the final report and other tasks related to the final close out of these experiments. Findings to date are available in a number of important areas including the effects of a negative income tax on work effort, health status, housing quality, school performance and marital stability.

The Welfare Administration Improvement Studies consist of a set of projects that analyze the cost and efficiency of various new methods of welfare administration. The absence of consistent and comprehensive data on administrative performance has, in the past, impaired the efforts of both Federal and State officials to develop policies and incentives to improve the management of welfare systems. These projects will constitute the first systematic attempt to evaluate administrative techniques and methods in terms of their impact on errors and costs.

The Monthly Reporting Projects, mandated by Congress, are part of the Welfare Administration Improvement Studies and are designed to study the impact of new client reporting systems for AFDC and Food Stamps.

Projects in welfare offices in three States examine the effect of retrospective accounting, monthly reporting and automated data support systems on administrative costs, quality control error rates and gross program outlays.

The Welfare Administration Experiments were developed based on initial findings from the monthly reporting projects that indicated that substantial cost savings and service benefits could be achieved by improving the administrative procedures of welfare offices.

These experiments will study the cost effectiveness of alternative methods of performing individual administrative functions, including alternative approaches to the performance of verification functions in welfare administration--an important target area for the development of more effective error reduction strategies. Alternative ways of performing tasks will be compared and evaluated in terms of the impact on quality control error rates, costs and the ability of clients to deal with the procedures.

The Health Insurance Study is a major experiment designed to measure the effects of different health cost prepayment and reimbursement insurance plans on the demand for medical care, the quality of care given and the health status of participants. Families at six sites are assigned to insurance plans having different coinsurance rates and out-of-pocket expenditure ceilings or to a Health Maintenance Organization. This study will provide information on how alternative cost sharing arrangements affect the demand for health care services. The study will also permit evaluation of many other health care issues, including the quality of care provided by Health Maintenance Organizations and the fee-for-service delivery systems and value of preventive care.

Interim results on the effects of coinsurance on the utilization of medical care have recently been completed and measures of health status have been developed.

The Retirement Policy Study is a multi-year project focusing on issues surrounding retirement, government policies that affect retirement decisions, and other household behavior in anticipation of retirement. Research will investigate the consequences of potential changes on the financing of the social security program, the present and future health status of the elderly and its implications for disability and the provision of medical services, the effect of social security and pensions on savings and related questions.

Regulatory Responsibilities

The Policy Research program imposes no non-Federal regulatory cost. The only federal regulatory cost involved in the program is the regulation governing grant applications for our grant funds which uses standard HHS research grant conditions. No funds appropriated under this program are used for regulatory development or enforcement by Federal staff.

Policy Research does, however, have a long-term role in reducing regulatory costs. Whenever pertinent, Policy Research projects focus on administrative aspects of policy alternatives, seeking efficient ways to achieve effective program reforms. As specific examples, the Monthly Reporting Projects and Welfare Administration Projects seek to identify low-cost alternatives for administering the AFDC program. The administrative procedures of AFDC are, of course, largely dictated by law and regulations.

Conclusion

In the Health and Human Services area, policy choices have great impact on people's lives and great impact on the Federal budget. It is imperative that we make such choices equipped with the best information that can be made available. It is our goal in the Policy Research program to try to predict future policy choices and data needs and to initiate investigations which will make these choices, if not easier, at least better informed.

ALAIR A. TOWNSEND

Assistant Secretary for Management and Budget
Department of Health and Human Services

Alair A. Townsend was sworn in as assistant secretary for management and budget, Department of Health and Human Services, Nov. 3, 1980. She had come to the Department of Health, Education, and Welfare in May 1979 as deputy assistant secretary for budget. HEW became HHS May 4, 1980.

Before joining the department, Ms. Townsend had served since January 1975 as associate director of budget priorities for human resources programs with the Budget Committee, House of Representatives. From August 1971 to December 1974 she was technical director for the Subcommittee on Fiscal Policy of the Congress' Joint Economic Committee.

Ms. Townsend's responsibilities include overseeing development of the department's budget, providing department-wide management guidance and maintaining a system for developing and administering financial operating plans. Ms. Townsend is principal advisor to the secretary for management, administrative and budget policies.

Born in Elmira, N.Y., Feb. 15, 1942, Ms. Townsend received a bachelor's degree in sociology, cum laude, from Elmira College in 1962. In her junior year she studied at the London School of Economics. She received a master's degree in sociology from the University of Wisconsin in 1964 and studied toward a doctorate at Columbia University, 1970-71.

After a year as a teaching assistant at the University of Wisconsin, Ms. Townsend worked at HEW from September 1964 to June 1965 as a program analyst. Between June 1965 and March 1967 she was a research associate with the United Planning Organization, Washington, D.C.

From March 1967 to February 1970 Ms. Townsend was a program specialist, first with the Model Cities Administration, Department of Housing and Urban Development, and with the President's Commission on Income Maintenance Programs. Between February 1970 and August 1971 she served as an analyst and consultant at HEW.

Ms. Townsend is a Phi Beta Kappa and former Woodrow Wilson Fellow.

Her published works have focused on economics, public welfare, income maintenance programs and policy analysis.

She is past secretary-treasurer of the Budget Officers Conference; member of the executive committee, Section on Budget and Financial Management, American Society of Public Administration; and a member of the editorial board of *Public Budgeting and Finance*.

Ms. Townsend is married and lives in the District of Columbia.

November 3, 1980

INTRODUCTION OF ASSOCIATES

Ms. TOWNSEND. Thank you, Mr. Chairman. On my left is the Acting Inspector General, Mr. Bryan Mitchell. On his left is the Acting Head of the Office for Civil Rights, Mr. Paul Kretchmar. To my far right is Gerald Britten, the Acting Assistant Secretary for Planning and Evaluation. To my far left is Mr. Tony Itteilag, the Acting Deputy Assistant Secretary for Budget, and on my right is Mr. John Scully, the Director of the Office of the Secretary, Budget Services.

Senator SPECTER. Thank you. And we welcome you gentlemen, and I was impressed with the chronology, all of which was very meaningful in the introductions.

FUNCTIONS AND MISSION OF OFFICE OF SECRETARY OF HEALTH AND HUMAN SERVICES

Ms. TOWNSEND. Mr. Chairman, in the spirit of your asking us to be as brief as possible, I'll be as brief as I can.

It's a pleasure to be here today to discuss with you the functions and the mission of the Office of the Secretary of Health and Human Services. Those functions and missions are supported by the five departmental management appropriations: General departmental management, the Office of Inspector General, the Office for Civil Rights, Policy Research, and a fifth, the Office of Consumer Affairs, which is not considered by this subcommittee and which we will not discuss today.

I will summarize the most important functions of these offices and areas, and then we will be pleased to answer your questions. We will start, if we may, with chart 1, and I believe you have letter-size versions for your convenience.

GENERAL DEPARTMENTAL MANAGEMENT

Chart 1 is general departmental management. General departmental management supports two kinds of activities, departmental direction supports those activities closely associated with the Secretary's role as policy officer and general manager of the Department. The second, departmental operations, supports the specialized staff services that we perform in the Office of the Secretary on behalf of departmental programs on a centralized basis for administrative efficiency and to avoid duplication of effort.

Chart 1 deals with the policy direction and general management role of the Office of the Secretary, the departmental direction portion. It includes the immediate Office of the Secretary, the Under Secretary, and the Executive Secretariat. The staff of the Assistant Secretary for Legislation, advises on the Department's legislative program and manages its presentation to the Congress.

The staff of the Office of the Assistant Secretary for Planning and Evaluation both conducts and coordinates the Department's program planning and evaluation activities. Program information, known as public information, is that body of activity related to explaining the policies and procedures of the Department to the public at large.

Management and Budget, my office, provides oversight of the Department's budget, financial management, grants and procurement and information management activities. Personnel administration supports policy oversight for all personnel activities, including general personnel policies, training, career development, equal employment opportunity, and the like.

Field management includes the immediate staff of the 10 principal regional officials who, as you know, are the Secretary's principal representatives in the regions.

Finally, there is included the General Counsel, being that activity devoted to legal policy for the Department.

The continuation of chart 1 deals with the departmental operations activities of the general departmental management appropriation. As I noted before, these are the centralized services which we perform on a centralized basis for the Department as a whole.

Facilities engineering directs all of the facilities' operations in the Department. It guides construction that is supported by federally assisted funds and conducts a program to channel surplus property to nonprofit grantees for health, income security, or social services purposes.

Administrative services provides a variety of general support, ranging from data processing, printing, laboring services, and processing of grants and contracts in the Office of the Secretary, and those supports of functions.

The grants payment system serves as a central payment and cash-control point for the Department. It does not itself award funds, but rather manages grants payments for the Department as a whole.

The regional services activity provides common administrative services such as personnel, finance, and indirect cost negotiations to our regional program components.

The employees' system center is another name for payroll and payroll processing for the entire Department. Legal services relates to the direct legal workload for the Department as a whole for all our agencies and components including the regions.

OFFICE OF THE INSPECTOR GENERAL

Next on chart 2 we have the Office of the Inspector General. This Office was established by the 94th Congress and initially funded in 1978. It coordinates and provides leadership for the Department's effort to promote economy and efficiency and to prevent fraud and abuse in our programs. The Inspector General also has a statutory mandate to keep the Secretary and the Congress fully informed about any problems or deficiencies in our operations and to suggest corrective action.

These statutory missions are accomplished by several principal activities. The Inspector General staff conduct audits, investigations, and systems reviews. They coordinate the Department's efforts for all of the agencies to detect, prevent and eliminate fraud, program misuse and management inefficiencies and, finally, they are the key contact point for developing working relationships with other agencies and with State and local governments in combating abuse in our programs.

A major and expanding commitment in the area of Federal/State working relationships is the State medicaid fraud control units program. This program provides formula grants to the States to enable them to establish fraud-control operations. These fraud control units are charged with identifying and prosecuting medicaid fraud; with reviewing, investigating, and prosecuting cases of patient-care abuse; and looking at State practices to identify corrective actions and ways in which the State can proceed systematically to avoid fraud, abuse, and mismanagement.

OFFICE FOR CIVIL RIGHTS

The third appropriation is the Office for Civil Rights. This Office is responsible for enforcing various civil rights statutes which prohibit discrimination on the basis of race, color, national origin, sex, age, and handicap in federally assisted programs and activites.

To enforce these statutes OCR has several major modes of operation. First, it conducts investigations of complaints of discrimination. Second, it conducts comprehensive compliance reviews of programs to both identify and correct discriminatory practices. Third, it provides technical assistance to our grantees to enable them on a before-the-fact basis, if possible, to correct possible areas of discrimination. In some instances, Mr. Chairman, this kind of technical assistance leads to easier methods that recipients can take to comply with the law.

There was some confusion, for example, with respect to how to comply with section 504, regarding access by the handicapped. Some grantees felt they had to do more than they had to do to be in compliance and to meet the needs of people. The technical assistance program helped the grantees in learning what it was they had to do as well as the ultimate consumers of our services.

Finally, the Office for Civil Rights establishes compliance standards and procedures. It sets out as clearly as it can what it is that constitutes discrimination in our programs.

We have approximately 25,000 entities receiving departmental funds. These include hospitals, extended-care facilities, day-care centers, adoption agencies, the list goes on and on. And OCR is charged in full with protecting the recipients of these services from discrimination.

POLICY RESEARCH

Finally, Mr. Chairman, there is the policy research appropriation, administered by the Assistant Director for Planning and Evaluation. It is the principal source of factual information and analyses for the Department in such areas as the characteristics of the low-income population, the distribution and impact of benefits under both current and proposed law, and analyses of issues such as the aging of the population, or long-term care, that really crosscut our several agencies in the Department. It is the only flexible research authority available to us for work on emerging issues of national significance. It is used to analyze issues and conduct research that can't be done under other authorities and auspices, but it is closely related and coordinated with the research that is done by the Department's agencies.

These policy research activities have made many important contributions to both policy development and the legislative process. Their findings, facts, models, and data enable us to be much more responsive to the Congress and to the Secretary in terms of sorting out and answering questions with respect to current and proposed policies.

Mr. Chairman, as promised, I have tried to keep my remarks brief so we may explore with you more fully those areas of particular concern to you.

FISCAL YEAR 1982 BUDGET PROCESS

Senator SPECTER. Thank you very much. As a preliminary matter, I note that your background included work with the Budget Committee of the House of Representatives and then technical director of the Subcommittee on Fiscal Policy of the Congress Joint Economic Committee.

Ms. TOWNSEND. Yes, sir.

Senator SPECTER. Did those assignments give you any special aptitude for very close scrutiny with a possible eye to budget cutting as it would relate to your current position?

Ms. TOWNSEND. I believe so, yes, Mr. Chairman. I was with the Congress a total of about 8½ years, as you mentioned. The 3½ years I spent with the Joint Economic Committee Subcommittee on Fiscal Policy was devoted to a full review of all income maintenance programs, be they cash or in kind.

And the issue there was not only how do you make programs smaller, but how do you make them more efficient and effective. My 4½ years with the House Budget Committee included a lot of time spent on alternatives to budgets presented both by the President and by the other substantive committees of Congress. As you know, the so-called and now-famous March 15 reports that the Budget Committees get from the authorizing and Appropriations Committees always requested much more funding than could be accommodated or were thought to be able to be accommodated, so we had to scrutinize these quite thoroughly.

So, I feel and I felt then, that I have spent a lot of time looking for alternatives.

Senator SPECTER. Does your background give you any special insights which, given their extensive latitude, enable you to suggest significant cuts in current HHS budget to cut it more than it was today?

Ms. TOWNSEND. Yes.

Senator SPECTER. Have you been given that latitude?

Ms. TOWNSEND. Yes, I have. There has been a back-and-forth process between the Department and OMB; and the Secretary and Under Secretary-Designate, the two chief policy officials of the Department, have asked me and the budget staff to be as forthcoming as we could be in terms of alternative ways to reduce the budget.

And we have put forward for their consideration a vast menu of possible choices.

Senator SPECTER. You say two chief officers, a Secretary, and who else?

Ms. TOWNSEND. The Under Secretary-Designate.

Senator SPECTER. Are you able to share those recommendations with us, or is that premature at the moment?

Ms. TOWNSEND. It is premature at this point, Mr. Chairman. We anticipate that the budget in its revised form will be made available on March 10.

I assume we will be able to brief your staff a day or so before that time. We are working as fast as we can to get the budget in shape, and there are still a few decisions that are open between our Department and the Office of Management and Budget.

Senator SPECTER. Is it unwise for us to take your time on an afternoon like today to discuss these matters in very incomplete form?

Ms. TOWNSEND. Let me say it might have been difficult yesterday, but for the moment, there is a hiatus in the back and forth.

Senator SPECTER. You just happened to have a free afternoon. Well, as a beginning Senator, I have not wanted to say too much, but it struck me as somewhat unusual that we would sit and have these extensive subcommittee hearings, not knowing what is really on our mind, having figures from Mr. Carter's 1982 fiscal year budget, and having broad overviews from Mr. Stockman.

But do you think this is an exercise that has some reality, even though we can't know your innermost thoughts as far as what the budget will be?

Ms. TOWNSEND. I hope it is useful to you in providing more in-depth information than in the course of the next set of hearings you will have as you focus on the numbers. Possibly this gives you a better opportunity to look at the policy and the organization of HHS and the way we operate.

Senator SPECTER. We can't be any worse off than we were at the start of the hearings, even, if you have the time.

Ms. TOWNSEND. I have the time.

MS. TOWNSEND'S APPOINTMENT

Senator SPECTER. OK. I note that you were appointed on November 3 to your position as Assistant Secretary. What is your expectation as to the future with respect to a permanent position? Do you anticipate being the permanent Assistant Secretary for Management and Budget?

November 3 is a very auspicious date, it was one day before the election.

Ms. TOWNSEND. If I may first talk about that date. Secretary Harris asked me in the middle of October to take this job. I agreed to do so, since the previous Assistant Secretary for Management and Budget was moving on to a university. I was officially the Assistant Secretary for Management and Budget on November 1, and the way things fell, I was sworn in on November 3. I realize the date looks a bit bizarre.

Senator SPECTER. Not a whole lot more than November 1.

Ms. TOWNSEND. I am a member of the senior executive service and a career civil servant. As such, under the normal terms of the senior executive service, I would be kept in this position until at least May 20, at which time the Secretary can determine whether he wishes me to stay or he wishes me to assume some other position.

Senator SPECTER. How was the date May 20 selected?

Ms. TOWNSEND. That is in law, I think—120 days after I get a new supervisor, as it were, the new supervisor is to look at me, me or any other member of the senior executive service, to decide whether he or she wishes to keep the SES member in that position.

Senator SPECTER. That 120-day rule applies even to somebody as high as an assistant secretary?

Ms. TOWNSEND. Yes, sir; although, of course, if the Secretary were to indicate to me before that time that he was uncomfortable with me in this position, I would certainly wish to leave the office before May 20.

I might add, if I may, Mr. Chairman, this position is one of two career assistant secretaryships in the Department. It has traditionally been, and is now, a career-reserve assistant secretaryship.

Senator SPECTER. So traditionally, the appointments have not shifted with new Presidential administration?

Ms. TOWNSEND. That is correct. The other is the Assistant Secretary for Personnel.

Senator SPECTER. I believe the new Secretary and you were in the same fraternity, Phi Beta Kappa——

Ms. TOWNSEND. We should know the same handshake, then.

Senator SPECTER. I would say you just might. Except there is no handshake for Phi Beta Kappa, I think.

POLICY RESEARCH STAFF

On the position of policy research, I notice on the charts that there are 15 positions and some $24 million allocated there.

Ms. TOWNSEND. Yes, sir.

Senator SPECTER. What is the reason for such a large budget with so small a number of positions to take up a salary?

Ms. TOWNSEND. May I direct that question to Mr. Britten, the Acting Assistant Secretary of Planning and Evaluation?

Senator SPECTER. Is the format to be followed that Mr. Britten and the others today are going to make statements, or just respond to questions?

Ms. TOWNSEND. Just respond to questions, if that is agreeable with you.

Senator SPECTER. That is fine. Sure.

Mr. BRITTEN. I think it is $22.7 million for 1981, in policy research. But, the moneys are in fact not managed by the 15 people that are shown on the chart. Those 15 people are associated with various and particular research tasks, such as long-term care, or specific policy research activities. The moneys in general are managed by the Assistant Secretary for Planning and Evaluation and the staff. There are 160-odd other positions shown on the chart.

Senator SPECTER. Could we have that chart again, so I could follow you, please? I have since been supplied with one.

Mr. BRITTEN. The point is that 15 people are devoted to specific tasks within policy research, and the overall management of policy research is done by other staff.

For example, there are three programmatic divisions in the Office of the Assistant Secretary for Planning and Evaluation. Each of the programmatic offices are headed by Deputy Assistant Secretaries and they manage a portion of that money for the Assistant Secretary.

Senator SPECTER. Well, you lost me, sort of. Where is that money spent? On the salary component, 15 people would occupy a relatively small amount, let's say $24 million for 1980 or $22,700,000 for 1981. Perhaps you could give us some idea of the amount of that appropriation which is for salaries. Could you?

Mr. BRITTEN. Roughly $600,000 of the money is for salaries and related expenses. The 15 positions that I mentioned are for particular tasks within policy research.

Five of them are for long-term care, five of them are for the monthly reporting study, which is a time-limited study mandated by the Congress; and five are for the survey of income and program participation.

Now, the majority of moneys in policy research, roughly 50 percent of the moneys right now, are devoted to three large experiments, principally a health financing or health insurance experiment and an income maintenance experiment, both of which have been going on for a considerable number of years.

HEALTH AND INCOME MAINTENANCE EXPERIMENTS

Senator SPECTER. How many experiments did you say are in process at the present time? Major ones?

Mr. BRITTEN. We have in process the health insurance experiments, which cost roughly $8 million in fiscal year 1981; we have in process the income maintenance experiments, and we have in process the monthly reporting and welfare administration experiments. Those are the large experiments.

Senator SPECTER. Could you describe each one of those, please?

Mr. BRITTEN. Yes, sir; the income maintenance experiments are basically to understand the behavior of people that are in welfare programs, in different types of welfare programs. Since the late 1960's four experiments have been undertaken. These were initiated by the Office of Economic Opportunity and transferred to us in the early 1970's. Experiments were conducted in New Jersey and Pennsylvania, one set; Gary, Ind.; Iowa and North Carolina; and, finally Seattle and Denver.

The Iowa and North Carolina experiments were conducted in rural areas. We are bringing these to a close. What they have shown, basically, is that people who are given a very liberal welfare benefit program with no work requirements, in fact clearly reduce their work some; particulary young adults.

Now with that in mind, the Department, which had originally been considering a negative income tax-type proposal, shifted to the welfare reform proposal in the Carter legislation, which had a very central work component.

More specifically it had a public jobs component; it also had a set of work requirement components not dissimilar to the current WIN requirements. These experiments, as I say, are drawing to a close now. We are just closing out the data and the people in them.

Senator SPECTER. You are suggesting that your findings were that if you had a component where some work was required along with the welfare payment, that people did in fact work, whereas if that requirement was not a part of the system, that they did not work?

Mr. BRITTEN. A work requirement does not necessarily mean the recipient must have a job. It does mean that recipients must be certified as either having a job or looking for one. Without that requirement it was found that they reduced their work. They reduced their work in some total aggregate, rather than reducing just the hours they work per week, they would just not work a percentage of time. They would spend the time either looking for work or in the home. The percentage was fairly significant for young adults.

WORK REQUIREMENTS

Senator SPECTER. Is there—under the Carter proposal, which you referred to, what was the shift in a work requirement, if any, from that which existed before?

Mr. BRITTEN. The welfare reform proposals that had been advanced by earlier administrations were essentially a negative income tax, with very little work requirement.

The Carter administration proposal——

Senator SPECTER. Was there any work requirement prior to the Carter proposal?

Mr. BRITTEN. Yes; there was a relatively minor work requirement similar to the current WIN program in that recipients in current programs must register for a work incentives program and look for a job, and that they also must partake in training.

The experiments also indicated, by the way, that some of those training programs made very little difference.

Senator SPECTER. So pre-Carter there was a requirement of registration for work incentives and a training?

Mr. BRITTEN. Correct.

Senator SPECTER. What was the consequence of that program with respect to inducing or stimulating those recipients to find jobs, obtain jobs?

Mr. BRITTEN. Basically, in the Carter program——

Senator SPECTER. I am pre-Carter now. You identified those elements as pre-Carter.

Ms. TOWNSEND. Well, those were welfare reform proposals which like the Carter proposal were never enacted.

Senator SPECTER. So, those items you identified were never enacted?

Mr. BRITTEN. The current law does have certain requirements. The pre-Carter proposal would have not done very much with these current requirements. It was a relatively free, fairly liberal program that did not strengthen those requirements to any degree. The Carter proposal would have strengthened those requirements by offering public service jobs directly, and adjusted the benefit payments of individuals to, in fact, whether——

Senator SPECTER. What I am trying to find out as a threshold is what were those requirements.

Mr. BRITTEN. The pre-Carter requirements were essentially two, and they are in current law. One is that the recipient for welfare must register for the work-incentive program and partake in training if that training is offered, and second, must seek work.

Now after a period of time, if that seeking did not come to fruition or there was no training given, the recipient would, in fact, be given a particular set of welfare payments.

Senator SPECTER. Then what happened by way of change under the Carter proposal?

Mr. BRITTEN. The Carter proposal basically would have adjusted benefits for an individual—and we are talking about males and people who obviously could work—they would have adjusted the benefits for those people and given them reduced benefits if they did not find work or did not take a public service job or training slot.

Senator SPECTER. A reduced benefit if somebody did not find work? Was there a determination made that that person couldn't find work?

Mr. BRITTEN. A determination would have been made as to whether that individual should have been able to find work. I am talking about the able-bodied right now, not the disabled.

TYPES OF WELFARE BENEFITS

Senator SPECTER. When you talk about welfare benefits, of course you are talking about a wide variety of benefits. One would be able-bodied people. Just by way of outline form, could you generalize how many different kinds of welfare benefits there are?

Mr. BRITTEN. There is the aid to families with dependent children program which focuses principally on women with dependent children. As a component of that program, some States have, and the Department partially funds an unemployed parent welfare benefit. That is not found in all States.

This provides coverage not only for single-parent families but also for two-parent families where incomes are sufficiently low to qualify for welfare.

There is also—and this has been talked about as a welfare program—the supplemental security income program. That is a program for the aged, the blind, and disabled.

Another program that has been cast in the welfare mold is a food stamp program. And there are other related programs, such as medicaid, which provides medical care for the recipients of the welfare programs, and for other eligible people as the States so choose.

Senator SPECTER. And then there is the welfare program to able-bodied men, which you started with, able-bodied people?

Mr. BRITTEN. That is essentially, under current law, only part of the aid to families with dependent children program and the States can elect to cover two-parent families where the father is unemployed. It is not a universal program.

Senator SPECTER. It would not cover a person who did not have dependent children?

Mr. BRITTEN. No; it would not.

Senator SPECTER. No Federal requirement?

Mr. BRITTEN. No Federal requirement that each State should have the AFDC-unemployed father program.

Senator SPECTER. There was a Federal requirement though that the other categories, which you have given, the States should have?

Mr. BRITTEN. The AFDC program, that is correct, and the food stamp program, that is correct. The supplemental security income program is essentially a direct federally managed program. There are some States that supplement the SSI program for their recipients.

Ms. TOWNSEND. Mr. Chairman, we would be glad to provide a roster of the programs within our Department that we would categorize as welfare; the terms and conditions of eligibility; and work requirements and expectations, and relate those to prior welfare reform proposals and the findings of the income-maintenance experiments if that would be helpful to you.

Senator SPECTER. Well, I think it would be and we would be very pleased to receive that information.

[The information follows:]

DHHS WELFARE PROGRAMS

Aid to families with dependent children—AFDC.—AFDC was enacted in 1935 to provide aid to needy children. In 1950 coverage was extended to needy parents, and in 1961 families with unemployed fathers could be included at the States' option (UF program).

AFDC is a joint Federal, State, and (in some States) local program. The Federal share of payments varies from State to State ranging from 50 to 83 percent. More limited Federal sharing is provided for Puerto Rico, Guam, and the Virgin Islands. The program is administered by State and local governments, and the Federal Government pays 50 percent of the administrative costs and 75 percent of training costs.

AFDC benefits are limited to families with children under 18, or at State option under 21 and in school, lacking parental support due to death, continued absence, and physical or mental incapacity. States have the option of providing benefits to families where the father is unemployed—27 States have elected to fund this option.

The work incentive program—WIN.—The work incentive program is designed to assist AFDC recipients to become self-supporting through a program of employment, work experience, and training. Employment and training programs are administered by the Department of Labor. Child care and other supportive services are administered by DHHS. Grants to States provide 90 percent of total costs.

Persons exempted from the program include children under 16 or in school, the aged and disabled, mothers with children under 6, custodians for ill or incapacitated persons, and persons living too far from a WIN training or employment program to participate. In States which provide AFDC benefits to families with an unemployed father (UF), the father must be registered with the State employment office. Refusal of a nonexempt recipient to participate in WIN will cause that person, but not the whole family, to become ineligible. In UF, refusal of the father to accept employment makes the family ineligible.

Emergency assistance program.—An emergency assistance program, with 50 percent Federal cost sharing permits States to provide temporary (30 days in a calendar year) assistance to families with children who are without available resources for reasons other than refusal to accept employment or training, to avoid destitution, or to maintain a home for the children. Slightly less than one-half of the States have elected this program.

Medicaid.—The medicaid program (title XIX of the Social Security Act) was enacted in 1965 to consolidate and expand grants-in-aid to States and Territories for medical assistance to welfare recipients and, at State option, to the medically indigent (whose income precludes eligibility for categorical cash assistance but is insufficient to pay full medical costs).

Medicaid, like AFDC, is a joint Federal-State program. Each State may choose whether or not to participate; only Arizona has no federally reimbursed program. The Federal share of payments to medical care providers varies from 50 to 78 percent, depending on relative State per capita income. The program is administered by State and local governments; the Federal Government pays for at least half of the administrative expenditures. The exact share depends on a complex formula of various sharing rates for different administrative expenses.

Medicaid benefits are available to recipients of either aid to families with dependent children (AFDC) or supplemental security income for the aged, blind, and disabled (SSI). Medicaid benefits are also available to the medically indigent (in the 30 States with medically needy programs).

Supplemental sercurity income for the aged, blind, and disabled—SSI.—The supplemental security income for the aged, blind, and disabled benefits program was enacted in 1972, and implemented nationwide in January 1974. The administration of Federal benefits is funded through open-ended appropriations from general revenues. States are responsible for financing benefits under State supplementation and the Federal Government pays administrative costs for all federally administered State supplements. The program is administered by the Social Security Administration in the 50 States and the District of Columbia. Puerto Rico, Guam, and the Virgin Islands continue to administer federally reimbursed programs of aid to the needy aged, blind, and disabled.

Individuals aged 65 or over or blind and disabled individuals (using the same definition of disability as social security disability insurance) are eligible for benefits if their income and assets are below specified limits. Entitlement occurs on an individual or couples basis.

Relationship to recent welfare reform proposal.—Prior welfare reform initiatives would have changed the existing array of programs by introducing greater uniformity among States for coverage and would have strengthened employment incentives. Tougher work requirements and increased funding for public service jobs were proposed as part of the system change.

RELATIONSHIP OF WORK TO BENEFIT LEVELS

Senator SPECTER. Back, Mr. Britten, to the issue of what your studies show, was it your finding that when benefits were reduced in the absence of an effort by the recipient to obtain private employment or other employment, that, in fact, other employment was obtained?

Mr. BRITTEN. To the best of my knowledge, the study did not investigate that particular set of questions. What it did investigate was whether, if you had a high level of benefits without a work requirement, work effort was reduced.

When you did have work requirements, when you did have a condition for working, the participants did work.

Senator SPECTER. Where you had a condition for working, the participants did, in fact, work, and when you did not have such a condition, they did not work?

Mr. BRITTEN. They reduced the percentage of time they worked.

Senator SPECTER. So, your suggestion is that if there was no requirement, there was less likelihood of any work being done on a voluntary basis by the recipients?

Mr. BRITTEN. That's correct.

Senator SPECTER. So what changes, if any, have been made in the—in your program as a result of those findings?

Mr. BRITTEN. The experiments, in fact, are phasing out. They just produced the knowledge. The policy information is available now. It was fed in into the Carter welfare reform program and will be considered by this administration in welfare-reforming activities.

Senator SPECTER. What is your recommendation based upon what you learned from that particular experiment? Do you have a recommendation?

Mr. BRITTEN. I think the recommendation is reasonably clear. It is that there ought to be some work-related requirement with any particular program we have in this area or at least a work-incentive provision.

As Ms. Townsend said, I think we can present this to you in a fairly succinct way by giving you the programs and what some of the policy implications are. We can present that to you for the record.

[The information follows:]

Findings From the Income Maintenance Experiments Regarding Work Incentives

The experiments were intended to test the effect of different tax rates and benefit level combinations on the amount of work low-income individuals would choose to perform. The experiments showed that:

Participants reduced their work effort by leaving employment for concentrated periods of time rather than by reducing the number of hours they worked per week. Husbands reduced their weeks of employment by about 4 to 7 percent, although more than half of the weeks they spent out of employment were used to look for other jobs.

Wives and female heads of households reduced their weeks of employment by larger percentage amounts than husbands. There was very little change among women in the number of weeks spent searching for employment. Women are likely to quit the labor force altogether if their financial circumstances permit. The additional time is sometimes spent in family care.

Young adults (age 18 to 23) reduced their work effort by significant amounts (24 percent for males and 18 percent for females). Work reduction was somewhat smaller among whites than among blacks or Hispanics.

Recent work still under review suggests that a large fraction of earnings and employment reduction for wives and young adults may be due to systematic underreporting of earned income rather than the reduction of work effort.

The Seattle/Denver experiment also added special manpower training subsidies.

These subsidies had positive effects on time spent in such programs though payments not specifically earmarked for this use had little or no effect. However, final analysis has shown that increased training had disappointingly small or no effects on wage rates, employment, and earnings.

WORK INCENTIVES

Senator SPECTER. Well thank you, and I would appreciate that. I would like to explore it further at the moment.

When you say work incentives, you mean if somebody finds a job they can keep part of their welfare benefits and still keep their compensation?

Mr. BRITTEN. That's correct. There are a variety of different ways to provide incentive.

One is, of course, a requirement for work. Another is to have a different set of benefit levels—to let them keep more of their welfare payment then they would if they didn't work.

Senator SPECTER. Is that essentially an outgrowth of the wage supplement program which was proposed by Robert Kennedy many years ago, or is that the historic background of it?

Ms. TOWNSEND. I think they both flow from some of the same sets of concerns, including how you deal with people who can work and are working, but yet do not have enough wages from their job to support their families, or who cannot find a job.

The wage supplement is most helpful to people who do have jobs. Typically, in a classic wage subsidy, the arrangement is that the Government sets a target wage and pays, let's say, half of the difference between the employer paid wage and the target wage. So that there is always an incentive for the employee to work more and there is always an incentive for the employer to pay more.

Senator SPECTER. Ms. Townsend, do you know if it's correct that Senator Robert Kennedy did propose such a wage supplement program in the 1966 range?

Ms. TOWNSEND. It sounds plausible and I think he did, sir.

Senator SPECTER. What problems, if any—is there such a wage supplement program in effect where a welfare recipient gets part of his welfare benefits, if he, in fact, has private income?

Ms. TOWNSEND. I guess I was being a little too technical as I was talking about a wage supplement program. In some respects, you can call the food stamp program and AFDC wage-supplement programs in the sense that earnings do not lead to dollar-for-dollar reductions in benefits. So in that respect, they are wage-supplement programs.

Senator SPECTER. The earnings do relate to some reduction of benefit albeit not dollar for dollar?

Ms. TOWNSEND. Yes, sir; that is correct. In some respects——

Senator SPECTER. Could you be specific with, say, as to food stamps on that?

Ms. TOWNSEND. For food stamps, I think the average benefit reduction rate is about 30 or 33 cents on the dollar. So that as you earn $1 more, you pay roughly 30 or 33 cents more for your food stamps.

Senator SPECTER. And what point in earnings does that start at? When do you start to pay 33 cents for one dollar's worth of food stamps, that is what you are saying?

Ms. TOWNSEND. Essentially from the first dollar, there are certain standard deductions permitted in the food stamp program. I cannot, at this point, recall the exact formula for the food stamp program. I would be pleased to give you that for the record.

I think now they have moved to a standard work-expense deduction for food stamps.

[The information follows:]

FOOD STAMP BENEFIT FORMULA

Food stamp benefits are computed by subtracting 30 percent of countable income from the cost of the thrifty food plan, which in January 1981 was established at $233 per month for a family of four living in the continental United States.

Countable income is defined by: Subtracting from total monthly income an $85 standard deduction, 20 percent of earned income, and up to $115 for child care expenses and excessive shelter costs. To illustrate: For a family of four with child care costs of $100 per month and earned income of $600 per month countable income would be $295:

(1) Establishing countable income:	
Earned income	$600
Minus standard deduction	−85
Minus 20% of earned income—20% of $600	−120
Minus child care	−100
Countable income	295
(2) Determining coupon allowance:	
Thrifty food plan	233
Minus 30% of countable income	−88
Coupon allowance	145

The formula would establish a coupon allowance for this family of $145 per month.

WORK EXPENSE DEDUCTIONS

Senator SPECTER. A standard work expense deduction, what does that mean?

Ms. TOWNSEND. Mr. Britten, can you help me here? Let's say when a family of four is applying for food stamps and the man is employed. The food stamp program does not calculate your benefits solely on the basis of gross income. They will allow a certain deduction for expenses related to work.

Mr. BRITTEN. Like child care and things like that.

Ms. TOWNSEND. Because an earned dollar is not a net dollar, as you know. There are taxes, social security, Federal income taxes, and work expenses. Part of the work incentive feature in the food stamp program is to allow some kind of standard deduction much as we get in the income tax, for people who do not itemize, for those work expenses.

Mr. BRITTEN. The reason that we have proposed a similar thing in the aid to families with dependent children program and the reason that it makes some sense is because previously the States—different States and, indeed, different welfare offices perhaps within States—were computing individual benefits based upon the particular circumstances of each recipient.

This, we found, created a lot of errors and a lot of miscalculations and led to overpayments and a variety of things one might characterize as waste. With a standard expense, we found that you could process the claim more rapidly and the overpayments were less.

Ms. TOWNSEND. Is the implication of that clear?

Senator SPECTER. Absolutely not.

Ms. TOWNSEND. Suppose I were a welfare recipient and I went in to see my caseworker and I could convince her that I needed my car to drive to work and that my car's tires were bare. So I could say that new tires were a work-related expense. Indeed, the gas for my car, the insurance for my car, all constituted work-related expenses.

Since I needed uniforms on my job——

Senator SPECTER. I get the illustration.

Ms. TOWNSEND [continuing]. My lunches, my taxes. So the idea is to draw some boundary around that, including child care and, say, not only does that kind of open ended situation put me at the mercy of my caseworker or the caseworker at my mercy if I am very inventive, but it leads to subjective judgments and it essentially creates an open ended situation.

So in many instances, we are moving toward standardized deductions or assumptions with respect to work expenses.

FOOD STAMPS

Senator SPECTER. What is your judgment for the proposal as to cutting off food stamp availability as I understand it, with the Stockman plan, that 30 percent above poverty level which, as I understand it, is calculated at $11,000 a year?

Ms. TOWNSEND. Mr. Chairman, food stamps, as you know, are not under the jurisdiction of our Department.

I am not familiar with the details of that Stockman proposal. I have been perusing Mr. Stockman's proposals in our area, and I don't feel qualified at this point to comment on the food stamp proposal.

Senator SPECTER. Well, you are in the middle of the welfare proposals. If I have accurately stated Mr. Stockman's plan to eliminate food stamps for those who earn more than $11,000. Do you have an opinion and care to express one, as to the propriety of that proposal?

Ms. TOWNSEND. Well, let me just lay out some considerations and refrain from expressing an opinion or a recommendation.

I think that any time policymakers look at some of our programs which are targeted on the low- and modest-income population, and they see that suddenly the modest- and low-income population is defined as, let's say, $11,000 for a family of four, they worry about that.

They worry about that because average income for a family of four is higher than that, but not hugely so.

And if you look at the distribution of income, let's say of families of four, you would find a lot of people bunched in that income range, probably from $10,000 to $15,000 or $18,000.

The higher you extend the benefit, like food stamps, the deeper into the income distribution and the more families you potentially affect.

I think in the instance of Mr. Stockman's proposal, his concern is how far into the income distribution should we go through income-tested programs.

Senator SPECTER. Do you know how far the benefits of food stamps go at the present time?

Ms. TOWNSEND. $11,000 and above in some instances.

Senator SPECTER. How much above do they go?

Ms. TOWNSEND. I am not certain. I could supply for the record for family sizes of various types how far up it goes.

It is a fairly standard calculation. But it can go above $11,000. You reach into a dense part of the income distribution. I think Mr. Stockman's concern is that we could assist these families in another way, through the income tax cut.

[The information follows:]

INCOME LIMITS FOR FOOD STAMP BENEFITS

Families are ineligible for food stamps when their countable income is above the poverty guideline. At the present time the countable income limit for a family of four is $7,450 per year, but a family could have as much as $12,312 of earnings and qualify for food stamps. The table below shows maximum net and gross annual income levels according to family size:

Family size	Maximum countable income	Maximum gross income
1	$3,790	$7,737
2	5,010	9,262
3	6,230	10,787
4	7,450	12,312
5	8,670	13,837
6	9,890	15,362

MINIMUM WAGE REQUIREMENTS

Senator SPECTER. Well, when you have finished your recommendations to Secretary Schweiker and have reflected on Mr. Stockman's proposals, I would be interested in the judgment, if you care to express one or a judgment from the Health and Human Services from your Department.

And that may be an inappropriate question in the nature of an exercise in futility to ask one branch of the executive department to express an opinion as to what the Office of Management and Budget may say, but if you care to do so, I think it would be of interest to this subcommittee.

Back to the wage supplement program, do you run into any problems, Mr. Britten, or perhaps, if this question goes to somebody else's jurisdiction, with respect to minimum wage requirements, labor's concern for recognizing minimum wages on people who seek to find some less-than-full-time employment, on that type of approach?

Mr. BRITTEN. I cannot give you a definitive answer on that.

We are looking—in a couple of areas—trying to determine some things like that and what they might do for employment—mainly for the disabled.

We have done a study on a supportive work program, essentially a wage subsidy program——

Senator SPECTER. Could you wait just one moment, please?

[Discussion off the record.]

Senator SPECTER. Would you proceed, please?

I just wanted to be sure as to timing that this was our only panel this afternoon.

Sometimes on our hearings, we have a number of panels and I am very interested in this subject matter and would like to pursue it, but I just wanted to be sure we weren't keeping somebody else waiting and would have to judge as to timespan.

I might ask all of you, if there is some special subject you want to cover, we will come to those as well.

Mr. BRITTEN. I could merely answer your question somewhat indirectly from what policy research is doing or has helped take a look at.

One thing it has taken a look at is a supportive work experiment, in which there were different groups of people: Drug addicts, including welfare mothers, and young juveniles that have dropped out of school. We have taken a look at that and the results are that welfare mothers respond fairly well. After a while, with some supportive work, they will continue to work after getting back into the labor force through a payment program for that purpose.

It doesn't seem to work too well for the drug addicts or the juveniles.

Senator SPECTER. My question is, do those people have to earn minimum wage, if you know?

Mr. BRITTEN. What I am saying is I don't know the answer to that particular question and how the minimum wage affects that.

I think what we find is that through some employment programs like that, when you have a minimum wage requirement, you may have some sort of problem.

We don't know yet how much of a problem. We are taking a look at that for certain classes of people and what sort of problems are out there.

Senator SPECTER. If you have people who can earn the minimum wage, then I would conclude that they would not need welfare payments.

So the question that I have is whether you have any experience or any knowledge on the subject matter as to the ability of people to get part of their money from welfare and part of their money from their own work and whether the money they got from their own work could be at less than the minimum wage if they were welfare recipients?

Ms. TOWNSEND. I am sure it happens, that sometimes our recipients of aid to families with dependent children, do, in fact, earn less than the minimum wage.

Senator SPECTER. Legally?

Ms. TOWNSEND. I am not certain.

Probably not legally, no, but there are people out there who will take whatever job they can get. If they can get a job as a domestic, if they can get a job picking fruit, if they can get a job babysitting, I am sure some people take it, legally or illegally.

WAGE SUPPLEMENTS

Senator SPECTER. There have been some programs, as I understand it, going back to the Kennedy wage supplement program from the late and middle 1960's, 1966, 1967, where a suggestion was made that if a person hypothetically were receiving $100 from a welfare line, and then could earn $50 himself and he could then get $75 from welfare, yielding a net of $125 which is higher and having welfare saving and having some contribution to the gross national product and perhaps only his earned income being subject to taxes.

My question is, has any such program ever been adopted and implemented?

Ms. TOWNSEND. What you are talking about, as I understand it, is a program under which benefits are reduced by less than a dollar for every dollar earned and nearly all of our programs and the food stamp program operate in that way.

Even the supplemental security income program for the aged, blind, and disabled, works in that fashion. And to a maximum, social security works in that way.

Typically, one earned dollar does not offset a benefit dollar fully.

Senator SPECTER. And what has the experience been with respect to people being willing to undertake that kind of income-producing activity?

Ms. TOWNSEND. I think part of the results of that kind of experience were summarized by Mr. Britten earlier.

It is really the flip side of the coin. You give someone a welfare payment, will they work? The fact is that we do have a number of working welfare recipients and for many people, given the exigencies of life, they are on and off welfare, depending upon whether they can find a job, whether their husband is around and/or employed. Those kinds of things.

So I think the general summary that Mr. Britten gave you about the impact of welfare on work would apply hereto.

Senator SPECTER. Did your studies, Mr. Britten, give you any insights as to what level to pitch this combination at, to try to stimulate people to do the maximum amount of work, cut down on the welfare payments to the maximum extent possible?

Mr. BRITTEN. They did. I don't have that in my head right now and would much prefer to try to provide that to you.

Senator SPECTER. All right. I would appreciate it if you would do that.

Ms. TOWNSEND. The experimental design was such that people were eligible for benefits at varying percentages of the poverty level.

So some families might have been eligible for benefits set at 100 percent of the poverty level, without work, and another for, say, 25 percent of the poverty level.

There were various control groups to test the impacts of both varying basic benefits without work and basic rates of take back of benefits as you do work.

Senator SPECTER. You say that test is now completed, Mr. Britten?

Mr. BRITTEN. That's correct. It is being phased out. I think the final one is now phasing out.

By the way, we have run a number of surveys of family behavior, and it is fairly clear that the welfare population will go on welfare—I am talking about the majority now—will go on welfare for a particular amount of time and then go off and work, and back and forth.

We can provide those conclusions to you as well.

Senator SPECTER. All right. I think the subcommittee would be very much interested in seeing those.

[The information follows:]

FINDINGS FROM THE INCOME MAINTENANCE EXPERIMENTS REGARDING THE IMPACT OF WELFARE BENEFITS ON WORK EFFORT

The income maintenance experiments were not designed to determine the ideal program nor could they have been designed to do so. The experiments were designed to test how changes in benefit guarantee levels and tax rates (the rate at which benefits decline as income rises) would affect work effort and program costs. In order to obtain precise estimates of the response to changes in guarantee levels and tax rates, a large number of programs were tested with guarantee levels ranging from 50 percent of the poverty level to 140 percent of the poverty level and tax rates of 30 to 80 percent. The experimental findings reveal that increases in both the guarantee level and the tax rate reduce work effort for program participants. However, as the tax rate is decreased the program breakeven point (the level at which AFDC benefits cease) rises. As the breakeven point rises the number of program participants rises, and more people face work disincentives.

The potential welfare population is heterogeneous and the findings reveal that each individual responds differently to a given program. Hence, what may be considered ideal for one family may not be ideal for another family. The experiments have been able to provide estimates of how many persons would reduce work effort in response to different programs and by how much, so that we can now estimate for other proposed AFDC reforms the effect on different groups within the program, and hence the overall costs and benefits.

FRAUD IN HHS

Senator SPECTER. What is the highest figure which has been circulated, Ms. Townsend, as to the cost of fraud within the HHS?

Ms. TOWNSEND. In the first Inspector General's report, he talked about fraud and abuse as about $900 million.

His larger total of $5 to $7 billion was fraud, abuse, waste, mismanagement, and so forth.

But for fraud alone, it was less than 15 percent.

Senator SPECTER. Well, that figure has been republished, attributable to fraud alone, and you are saying that that is inaccurate?

Ms. TOWNSEND. Yes; that is inaccurate.

Senator SPECTER. Where did the $5 to $7 billion figure originate? You say, in an Inspector General's report?

Ms. TOWNSEND. Yes, sir; the first annual report of the Inspector General, where he discussed the total of various problems known at that time, including waste, mismanagement, abuse and fraud, related to the Department's programs.

The first report was issued in 1978 with respect to fiscal year 1977. At that time, he calculated that the waste, abuse, and fraud total was from $5.5 to $6.5 billion.

And of that, about 15 percent was thought to be related to fraud and abuse, as opposed to waste, mismanagement and so forth.

Senator SPECTER. What would the category of waste cover, Ms. Townsend?

Ms. TOWNSEND. It would be, I suppose, provider inefficiency, keeping patients in hospital beds longer than they need to be, and so forth.

Perhaps the appropriate person to answer on the definition of waste would be the Acting Inspector General.

Senator SPECTER. May we hear from you, Mr. Mitchell?

Mr. MITCHELL. The term "waste," Mr. Chairman, was used by the Inspector General at that time in a very broad and generic sense.

He used it in the sense of any dollar that could be saved, that was not being saved and that was not attributable to fraud or abuse.

It covered many things, as Ms. Townsend has pointed out. It covered the dollars that were being spent as well as those estimated to be spent at that time.

For example, some dollars could be saved by second-opinion surgery while others could have been saved by hospital costs containment.

So, the definition that he used for waste was a very broad and generic one. It essentially said that if it is possible to save these dollars, and they are not, then they are being wasted.

Senator SPECTER. And the item attributable to fraud was calculated at $900 million?

Ms. TOWNSEND. That was fraud and abuse?

Mr. MITCHELL. Fraud and abuse, sir.

Senator SPECTER. What is "abuse" in that categorization?

Mr. MITCHELL. "Abuse," as used by the Inspector General at that time, sir, was a very limited definition. It applies mostly to health care financing programs.

I can best illustrate this to you. If I go into a physician's office and have, for example, a broken finger, and that is all I have, and I get a whole series of tests and chest X-rays and I am sent to see other kinds of specialists, then there is abuse even though the service is indeed rendered.

So the physician, when he charges the program, is not falsely charging the program because he's charging for a service that is actually rendered. But it is a service that is not needed.

So the term "abuse" covers those kinds of situations.

Senator SPECTER. Was there any figure specified for fraud alone?

Mr. MITCHELL. I don't recall a figure for fraud alone, sir. I can check the record and supply it to you, if there is a figure for fraud alone.

This whole exercise that covered this, actually covered a 2-year period, starting out being published first in the first Inspector General's report and was carried on into the second Inspector General's report where the numbers were considerably refined.

[The information follows:]

DOLLAR FIGURE FOR FRAUD ALONE

The Inspector General has never differentiated estimated losses between fraud and abuse. In May 1978, the Inspector General estimated total losses between $5,521 to $6,532 million. He estimated total losses due to fraud and abuse at $886 million and stresses that "fraud and abuse" was the smallest part of total losses (i.e., 15 percent). Of the $886 million figure, $218 million was attributed to recipients and $668 million to health care providers.

MANAGEMENT RESPONSE TO IG RECOMMENDATIONS

Senator SPECTER. In a February 2 article in the Washington Post, the Inspectors General dismissed by the administration contended while waste and fraud are prevalent, that mismanagement and inefficiency do the greatest damage to the taxpayer's wallet.

Why are the Inspectors General complaining that program managers in the various agencies are not held accountable for correcting the problems uncovered?

Mr. MITCHELL. I would have to assume, sir, that those that are complaining, are doing so because program managers do not respond to recommendations for corrective action.

Senator SPECTER. Well, are you familiar with any instances within HHS where the program managers were not responsive to the Inspector General's complaints within your Department?

Mr. MITCHELL. Not in any large sense, sir. There may be some recommendations where they have not been responsive.

Senator SPECTER. Can you be specific on any?

Mr. MITCHELL. Not at the moment, sir. By and large, I would say since the Office of the Inspector General has been there, the Department has responded well to our recommendations.

That is not to say that everything has been cleared up. Some of these things take a good many years to get all of the action done.

Senator SPECTER. How long have you been in the Inspector General's Department of HHS?

Mr. MITCHELL. It will be 4 years next month, sir, that the Inspector General will actually have been in operation.

Senator SPECTER. Does that apply to you personally, that is my question?

Mr. MITCHELL. I have been in the Inspector General's Office the whole time, sir.

Senator SPECTER. All 4 years. Is it your testimony that you know of no situation where a program manager has not responded to the recommendation or finding in the Inspector General's Department?

Mr. MITCHELL. I can't say that, sir. Because we turn out over 5,000 audits a year. I can say that on the large-scale recommendations, the Department has been responsive.

There are probably a good number of small recommendations, or areas where people in the Department just don't agree with us. By responsive, I mean that a program head will consider your recommendations and sit down with us and actually discuss them, not necessarily that they always agree with us.

Senator SPECTER. Well, my question to you was whether you know about any situation where the program manager has not responded.

I understand that there are thousands in issue. But I am trying to get at something specific, aside from the generalization, to test what the Inspector General is doing, and what the program manager is doing.

That is why I am asking you whether you have any knowledge of any specific situation where the program manager did not respond to the Inspector General's complaint, or request.

Mr. MITCHELL. Let me phrase it in this way, sir. There are certainly areas where they have not adopted all of our recommendations. For example, an audit and study that was done on the contracting procedures at the National Cancer Institute is an example of where not all of our recommendations have been accepted.

Senator SPECTER. What recommendations, just to explore the area, have not been accepted?

Mr. MITCHELL. At the National Cancer Institute, sir?

Senator SPECTER. That is the one you mentioned, yes.

Mr. MITCHELL. Yes, sir; one that has not been accepted in its entirety is the relationship of the contracting granting function to the scientific oversight.

Senator SPECTER. What does that mean?

Mr. MITCHELL. To take it in pure and simple words, to set up barriers so that the scientists cannot direct contracting offices how to do the job.

ENERGY AUDIT

Senator SPECTER. The Department of Health and Human Services was recently criticized in separate audit reports by the Department's Inspector General for wasting $790,000 a year in energy consumption and for sloppy handling of more than $250,000 in overtime.

Why is internal auditing not catching obviously wasteful trends in management?

Mr. MITCHELL. I would respond to that, sir, by saying internal auditing is catching it, that is what the two audits were about. This is what they revealed. It seems to me that is what internal auditing is about.

Ms. TOWNSEND. May I speak to that issue, Mr. Chairman?

Senator SPECTER. By all means.

Ms. TOWNSEND. I would like to speak first to the energy conservation issue. We have in the Department a very firm commitment to energy conservation.

As proof of that, I would submit the following. We have met all of our goals since 1972, and we are fully confident that we will meet our future goals.

Second, my office——

Senator SPECTER. Let me interrupt you on that. The staff of this subcommittee has provided us with information that there was a wasting, that the Department of Inspector General found a wasting of $790,000 a year in energy.

Ms. TOWNSEND. My office asked the Inspector General for that audit.

And what I would like to do is speak specifically to that $790,000 estimate, because I disagree with it.

I think this was an instance where the facts are not entirely as they were presented.

Senator SPECTER. Was any part of that acccurate?

Ms. TOWNSEND. Yes, sir; I believe so.

Senator SPECTER. How much?

Ms. TOWNSEND. Less than half. I believe that $465,000 of that relates to the Parklawn Building. That is not a building that we own. That is a leased building. If we conserve energy there, those savings accrue to the person from whom we lease.

Senator SPECTER. Aside from the dollars figure, the energy savings are important otherwise now. And if you reduce costs to your landlord, isn't that likely to be reflected in your rent at some later time?

Ms. TOWNSEND. It could. It depends how GSA renegotiates the leases.

Senator SPECTER. But is there any justification for waste, even if you are not paying for it?

Ms. TOWNSEND. No, sir; the waste in this case referred to replacing 40-watt bulbs with energy-efficient 35-watt bulbs, replacing unnecessary lighting, turning off equipment, and so forth. Now, we should turn out lights, we should be good tenants and energy conservers wherever we are.

Federal regulations and commonsense also require that energy conservation measures should be cost-efficient. In this instance, I have another problem. It is not dollars-and-cents efficient to replace 40- or 50-watt light bulbs with 35-watt fluorescent light bulbs out of cycle.

These things have a natural life. There is a normal, what they call relamping schedule, where they go through buildings, take old bulbs down, and replace them with new ones. It would cost more than it would save to go out of those cycles, to take down partially burned-out bulbs and put in new bulbs,

Senator SPECTER. You think the Inspector General was wrong about that conclusion?

Ms. TOWNSEND. I guess that is the bottom line. I would disagree——

Senator SPECTER. How do you feel about her disagreeing?

Mr. MITCHELL. As I told you previously, on all programs, the managers don't always agree with us.

Senator SPECTER. I want to find some agreement or disagreement. All I found is disagreement.

Mr. MITCHELL. I would say, Mr. Chairman, if Ms. Townsend replaced the 40-watt bulbs with 35's when the 40 burned out, it would be a very nice way to both use the present bulbs and get an energy savings.

Senator SPECTER. So you think you're both right?

Mr. MITCHELL. Yes.

OVERTIME AUDIT

Senator SPECTER. How about the allegations of sloppy handling of over $250,000 of overtime? Ms. Townsend?

Ms. TOWNSEND. Who would you like to respond on that?

Senator SPECTER. Take your choice.

Ms. TOWNSEND. Ladies first. This is an area in which we, too, are concerned. What was uncovered was the fact that we have, as I think Mr. Mitchell would agree, reasonably good policies and procedures. They were not being followed. I would like to emphasize, however, and I believe the Inspector General would agree, that no instances of fraud were uncovered. I think that is important.

Senator SPECTER. No instances of fraud uncovered. Do you agree with that, Mr. Inspector General?

Mr. MITCHELL. I do.

Senator SPECTER. Do you think you have an effective Inspector General's Office if no instances of fraud were uncovered in the Department of Health and Human Services?

Mr. MITCHELL. Only as it relates to overtime, sir. There is a lot of other fraud in there.

Senator SPECTER. Even as it relates to overtime. How many people do you have working on that subject?

Mr. MITCHELL. At the moment, we have no one working on it, but we are going back in 90 days and recheck the action that the Secretary has directed the managers of the Departments to instigate.

Ms. TOWNSEND. If I could add a comment here——

Senator SPECTER. Before you finish that. Is it your professional judgment, Mr. Mitchell, that there is not a problem of fraud in overtime within Health and Human Services? Whether you have detected it or not?

Mr. MITCHELL. I could only speculate, Mr. Chairman.

And based on my knowledge of things that have happened in the past, I can only speculate that there may be someone who's defrauding the overtime situation.

Ms. TOWNSEND. I would assert that that is probably true. In this specific instance, however, no evidence of fraud was uncovered.

I think that the Inspector General did management a service by reminding us that one of our duties is to control this area: despite that, no wrongdoing was uncovered. The Secretary has written a very strong memo to all of us who manage, reminding us of our duties.

He has tightened the rules to avoid fraud and if I could, sir, I would like to submit that memorandum for the record.

Senator SPECTER. Yes, please.

[The information follows:]

FEBRUARY 18, 1981.

Memorandum to: Heads of principal operating components: heads of OS staff offices: and principal regional officials.

Subject: Strengthening controls on overtime.

I have just become aware of the attached December 1, 1980, report by our Inspector General of his 1978 review of internal controls over the payment of overtime. The report reveals numerous and significant discrepancies in our offices with respect to compliance with procedures for requesting, authorizing, and documenting overtime and for controlling overtime payments. While the report does not identify specific instances of fraud or illegal payments, it clearly identifies control failures with a high potential for fraud and abuse.

The four major problem areas identified in an initial draft of the report by the Inspector General and the needed corrective actions were brought to your attention by the Assistant Secretary for Personnel Administration in December 1979. At that time, you were asked to remind your managers and supervisors of the importance of effective implementation of overtime policies and to develop a plan for strengthening the implementation of those policies. The December 1 report states that the problems still exist.

We cannot tolerate any further delay in taking the necessary steps to eliminate completely any deficiencies in our oversight and control of overtime. To that end, I am directing the following actions be taken:

Each component head will take immediate steps to insure that managers and supervisors are properly authorizing, certifying, and documenting overtime. You should evaluate a sufficient sample of your overtime usage across the country to convince you that your supervisors and managers are in full compliance, and will stay in full compliance, with governing policies and procedures:

The Inspector General will conduct a followup audit of overtime control procedures after 90 days and report the findings directly to me: and

The Assistant Secretary for Personnel Administration will review overtime policies and procedures for sufficiency with particular attention to internal payroll audit and control procedures, will increase the number of timecards audited each fiscal year, and will complete and distribute the new timekeeper manual and self-training package by March 31.

Finally, the audit report reveals some cases of overtime worked at home. This practice cannot be adequately controlled, and I want steps taken immediately to eliminate it.

The Department's poor record in exercising control of overtime payments represents, in itself, a potential area for substantial fraud and abuse. When you identify performance failures in this area, I expect you to take prompt and direct action to correct them. I want to be sure that our managers understand we expect effective management and control of overtime. We will not tolerate an attitude of indifference with respect to this situation.

RICHARD S. SCHWEIKER,
Secretary.

INSPECTOR GENERAL AUDIT

Ms. TOWNSEND. It is worthwhile at this point to emphasize what Mr. Mitchell said, that the Secretary did say that within 90 days there would be a followup Inspector General audit, to make sure that those of us who manage are in fact doing a better job.

Senator SPECTER. Did any firing result, or any disciplinary action get taken, as a result of the Inspector General's report as to any of those who were responsible for these items?

Ms. TOWNSEND. No, sir.

Senator SPECTER. You felt none was called for?

Ms. TOWNSEND. My honest view is at least in my own bailiwick that I know about, is that none was called for.

I can't speak to the conditions which the Inspector General might have found in other areas. We have revised managerial delegations for control of overtime.

COMPUTER SYSTEMS SECURITY

Senator SPECTER. What is being done in the various income maintenance programs, and in the Social Security Administration, to prevent employees who access the computers from diverting benefit checks to themselves?

Ms. TOWNSEND. My office has responsibility for something called systems security. We are concerned about the instances that you sometimes hear about.

I do not have with me a detailed summary of our progress to date. Could I submit our action plan and our progress to date to you for the record, and simply say at this point that I have a small, hardy staff devoted to that effort?

We work in concert with the agencies and their designated systems security people. As technology grows more sophisticated, this is an area across government and across business that must concern us more and more. As more and more things can be put on computers, there is always a concern that someone, who should not have access to that information, can get it for whatever purposes.

[The information follows:]

PREVENTION OF SYSTEM SECURITY VIOLATIONS—COMPUTER FRAUD

The Department of Health and Human Services has developed and operated an effective ADP systems security program by establishing the policies and requirements for insuring ADP security in compliance with OMB directives. These policies and requirements encompass on-site security reviews of ADP activities, training of HHS personnel for awareness with systems security requirements, and following up on systems security violations to insure corrective action. In addition, HHS has conducted formal on-site evaluations of 10 ADP systems/installations, trained over 200 ADP systems professionals to assume leadership roles in ADP security programs, and involved over 2,000 ADP professionals in administering and reporting on ADP security compliance.

DUPLICATE CHECKS

Senator SPECTER. Are you satisfied with the progress that you are making on that particular problem?

Ms. TOWNSEND. I hope we can do better. We need to do better, and I think we will.

Senator SPECTER. Let me amplify a slightly different direction.

As it relates to obtaining duplicate checks by those who claim that their benefit check has been misdirected, or has not been received by them, what are your procedures at the present time on that subject?

Ms. TOWNSEND. Such as social security checks or payroll checks?

Senator SPECTER. Social security or a welfare check.

Ms. TOWNSEND. Well, if it were a supplemental security income check, we would have jurisdiction. If it were an AFDC check, that is a State issue.

Mr. Chairman, I regret I don't have that information. If the Commissioner of Social Security has not yet appeared, we will ask him to answer that, or else submit it for the record.

[The information follows:]

STEPS WHICH ARE TAKEN WHEN A SOCIAL SECURITY CHECK IS NOT RECEIVED

Claimants visit or telephone SSA's district and branch offices when they fail to receive their social security checks. SSA does not act on the request until 3 days after the normal check delivery date in case the check was delayed in the mail. After the third mail delivery day passes, the claimant completes a nonreceipt form and agrees not to cash both the original and substitute checks.

The nonreceipt allegation is electronically directed to SSA's computer facility to verify that the claimant is in current pay status. Proper nonreceipt claims are transmitted to the Treasury Department. If the original check was not negotiated, a subsitute check is issued. Double negotiations may occur if the original and substitute checks are negotiated later. Where double negotiation occurs and the signatures are the same, the Treasury Department charges SSA who treats the case as an overpayment and pursues recovery. If the signatures are different, then the Treasury Department initiates a fraud investigation.

Similar procedures are in place for the SSI program except for current month's checks. If a current month check is not received, a substitute check is issued immediately without checking to see if the original SSI check was negotiated.

SAFEGUARDING AGAINST DUPLICATE CHECKS

Senator SPECTER. I do know that that has been a major problem from time to time, and I would be interested to know what safeguards are in effect to prevent people from requesting and being issued duplicate checks. I guess there have been very material losses on the fraud line on that in the past.

Mr. MITCHELL. I might add, Mr. Chairman, that we have a project going now, working with many other Government agencies and our own people, on this very problem.

We would be happy to provide that information for the record to you if you like.

Senator SPECTER. Can you give me some insight to it at the moment?

When material is provided for the record, it is important that it is transcribed and it is reduced to writing, but there is a material risk that that doesn't come to anybody's personal attention at the same level as if it is articulated here today.

And I realize you can't be prepared on all of these subject matters, but if you know something about that subject, I would be interested to hear it at the point in time.

Mr. MITCHELL. We have two or three projects going, Mr. Chairman, that have to do with stolen checks and duplicate checks.

What happens to the first check when a second check has been issued? Who cashes that first check? Does it ever turn up again? This type of project.

We have got one project going that we are getting ready to run and are now underway, as far as title II of the Social Security Act is concerned, where we were actually going to get the cashed checks and look at the back of them, the same thing that you would do with your checks when they come back home, to see who cashed them.

Because of the millions of Government checks, very few of them are turned over to see who cashed that check. We have just gotten that project underway.

Senator SPECTER. You are doing that where there are reports of checks being lost or stolen?

Mr. MITCHELL. This one that I just mentioned, Mr. Chairman, we are doing without the check being reported stolen. We are doing it on a statistical sampling basis to get at all of the checks, if you will.

Senator SPECTER. Have you done that with the checks which have been reported as lost or stolen?

Mr. MITCHELL. We are also working on a separate program——

Senator SPECTER. It is a massive undertaking, even on a sampling basis, to check the checks?

Mr. MITCHELL. We started out, Mr. Chairman, calling it Operation 1,000, and I think we are now calling it Operation 7,000.

Senator SPECTER. What is it, 1 out of 7,000?

Mr. MITCHELL. 7,000 checks on our first sample.

Senator SPECTER. Out of how many? Does anybody know how many? Can it be determined?

Mr. MITCHELL. I don't think anyone even knows what the universe is, but we have a sophisticated statistical sampling process that will allow us to draw some conclusions from the first 7,000 we look at, that will then tell us what we need to do more. We are also looking at, in turn, the stolen checks.

We are also looking at areas where they have different delivery methods of the check, such as whether they send the check in the mail, whether the beneficiary is required to pick it up, or whether you have some other type of delivery system for the check.

Senator SPECTER. In cases where there is a duplicate check issued, do you at least on those situations, make an effort to retrieve the first check and determine who the endorser was there?

Mr. MITCHELL. We are doing that in our study.

Senator SPECTER. Well, aside from your study, do you do that otherwise?

Mr. MITCHELL. Consistently?

Senator SPECTER. Yes.

Mr. MITCHELL. No, sir; we don't.

Senator SPECTER. It is true, is it not, that you do issue duplicate checks for someone who reports that he or she has not received a check?

Mr. MITCHELL. The Social Security Administration, yes, sir, issues duplicate checks there. And they have a quality-control process of that.

Senator SPECTER. Your unit does not?

Mr. MITCHELL. We do not routinely check all checks that have been reported——

Senator SPECTER. My question is, Do you issue duplicate checks where someone has reported a check not having been received?

Mr. MITCHELL. The programs do, yes, sir.

DISMISSAL OF INSPECTORS GENERAL

Senator SPECTER. On January 20, President Reagan dismissed 14 Inspectors General Governmentwide, including the Acting Inspector General in Health and Human Services.

What impact has the dismissal of the HHS Inspector General had on the ongoing investigation of new projects that are being considered by your Department?

Mr. MITCHELL. That is a very difficult question to answer, Mr. Chairman, but I would have to say that in terms of the ongoing work of the Office of the Inspector General, the work is going forward.

Senator SPECTER. It didn't make any difference that he fired the top man?

Mr. MITCHELL. It is hard to say, since he's not there, you don't have his leadership, you don't know——

Senator SPECTER. Well you had some comparison, he had been there?

Mr. MITCHELL. That's correct, sir.

Senator SPECTER. Would you care to express a judgment on that?

Mr. MITCHELL. I would not care to express a judgment.

Senator SPECTER. Ms. Townsend, you can take over on this line of questioning, if you care to.

Ms. TOWNSEND. Thank you for that generous offer. [Laughter.]

Let us say that some of us who get the Inspector General's reports on energy and overtime, have not noticed the Inspector General's Office missing a beat.

Senator SPECTER. You wouldn't accept that invitation to get even?

Ms. TOWNSEND. No, sir.

OFFICE FOR CIVIL RIGHTS

Senator SPECTER. Moving on to the Office for Civil Rights, that is your Department, Mr. Kretchmar?

Mr. KRETCHMAR. Yes.

Senator SPECTER. Could you describe in a general way how your office functions, by way of elaboration to what Ms. Townsend has testified to earlier?

Mr. KRETCHMAR. Our basic mission is to insure compliance of recipients of departmental funds with various civil rights statutes. The primary ones being the title VI of the Civil Rights Act of 1964——

Senator SPECTER. Which provides?

Mr. KRETCHMAR [continuing]. Which prohibits discrimination on the basis of race, color or national origin. And section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of handicap. The basic function of the office, then, as I said, is to insure compliance with the law through three major program activities.

The first is the investigation of complaints of discrimination that are filed with our regional offices. And which we attempt to investigate as promptly as possible.

The second is the conduct of compliance reviews of various recipients of Federal funds, and the third is the conduct of a technical assistance program to provide assistance to recipients and information to recipients, so that they can voluntarily comply with the requirements of our regulations.

RACE DISCRIMINATION COMPLAINTS

Senator SPECTER. As to category 1, are there many complaints that there is discrimination based on color?

Mr. KRETCHMAR. Yes; we received last year a total of 1,776 actual complaints of discrimination that were filed with our office. Of those, a majority deal with section 504 and the remainder deal with title VI. So we do get a significant number——

Senator SPECTER. The majority turns on handicap?

Mr. KRETCHMAR. The majority right now do deal with issues relating to handicap discrimination.

COMPLAINT DATA

Senator SPECTER. Do you have a statistical breakdown as between section 504 and title VI?

Mr. KRETCHMAR. Yes, I do. Of the 1,776 complaints, 934 were identified as issues related to section 504, 31 related to title IX, which is a provision dealing with sex discrimination in education. We can talk about that if you wish, and why we act on those complaints.

Title VI had 304 complaints and the remainder were multiple allegations under these statutes or involving other civil rights-related requirements.

But I would say that title VI would be the predominant issue that would be covered in those complaints that were not identified as section 504.

COMPLIANCE REVIEW STAFF

Senator SPECTER. The fiscal 1982 OCR justification states that 190 positions will be assigned to conducting 172 compliance reviews. That is less than one compliance review per person, per year. And the question is why do you need so many positions for that amount of workload?

Mr. KRETCHMAR. Many of the compliance reviews and, in fact, many of the complaint investigations involve very complex issues and, in many cases, require investigation of large health care systems or providers.

One of our compliance reviews last year dealt with the New York City Hospital Corp., and the possible—the eventual closure of a hospital in New York City.

Over 12,000 hours were devoted to that one single investigation.

In terms of our overall workload, we do have support staff that are also involved in providing guidance and program management to our investigators; and we also devote a lot of time to our complaint investigations. So, in fact, a bigger part of our staff is devoted to investigation of complaints, rather than the conduct of compliance reviews.

We have estimated that our current productivity is about two and one-half compliance reviews per investigator and five investigated complaints per investigator.

This is based on the amount of work that has to be done to collect the information necessary to substantiate that a violation may exist, to conduct negotiations with recipients to try to resolve the questions in a voluntary way, and then if necessary, write up the case, and possibly go through the enforcement process.

FEDERAL ENFORCEMENT PROGRAM

Senator SPECTER. Is it characteristic, Mr. Kretchmar, for each department to have its own office for civil rights?

Mr. KRETCHMAR. Traditionally, that has been the way that the civil rights program has been organized in the Federal Government. At one time, in the 1960's, our office was actually subdivided, with separate offices for civil rights under different names, in each of the major program operating components.

Senator SPECTER. That is no longer, then, you are at least consolidated to the extent of having one office for all civil rights issues within the Department of HHS?

Mr. KRETCHMAR. Yes; and there is a major civil rights office in the Department of Education, and just about every department, to my understanding, does conduct the civil rights program in this manner.

Depending on the nature of the jurisdiction, generally the Department of Justice has been over time, and more recently in the case of section 504, given the overall coordinating responsibility for civil rights enforcement in the Federal Government.

COURT ENFORCEMENT

Senator SPECTER. Is it a frequent occurrence for complaints which emanate from your Department to find their way into the Justice civil rights divisions for criminal prosecution?

Mr. KRETCHMAR. No; I am not sure that criminal prosecution is the right term. Civil enforcement, civil prosecution, might be a better term.

We have referred cases to the Department of Justice to seek court action in some of our civil rights cases. It has not been that frequent. If you would like more information, however, with your permission, I would like to ask our Assistant General Counsel for Civil Rights.

[A brief recess was taken.]

Mr. KRETCHMAR. Going back to my earlier statement, we have an inventory each year of carryover compliance reviews that, because of the length of time involved, are not completed within a fiscal year. So, in fact, the total compliance review workload would be higher than just new reviews.

We will have additional reviews that we will be completing, so that total reviews for the year will be more than 172.

Mr. Hamlin?

REFERRAL OF CASES

Mr. HAMLIN. Your question was whether or not we referred cases to the Department of Justice for criminal prosecution? Let me correct that. That is not for criminal prosecution.

There are two means by which the civil rights laws are enforced. One is through the termination of Federal financial assistance to noncomplying recipients.

The other, under title VI, for example, says other means authorized by law. We have determined that the other means authorized by law is pretty much limited to referring a case to the Department of Justice for preliminary injunction, or permanent injunction, as the case may be.

When we were the Department of Health, Education, and Welfare, a number of cases involving education matters were referred to the Department of Justice. That is usually up to the judgment of the Director of the Office for Civil Rights, or the Secretary, depending on the magnitude of the case.

And it was whether or not compliance would better be obtained through an injunction, or through at least the threat of the termination of Federal financial assistance.

Since we have had the split in May, no cases have been referred to the Department of Justice.

As a matter of fact, we have not had any enforcement actions taken under—in health and welfare programs.

Senator SPECTER. What split are you referring to?

Mr. HAMLIN. From the Department of Education, being split off.

Senator SPECTER. So that the conclusion is that the remedy is sufficient to terminate funding, as opposed to——

Mr. HAMLIN. We have not done either. We have not actually done either since May. There have been ongoing investigations. There have been findings of noncompliance.

There have been negotiations, and there have been actions taken by recipients to come into compliance.

There have been no cases since May that required us to go into a formal enforcement procedure. Either by referral——

Senator SPECTER. How about prior to May?

Mr. HAMLIN. I'm sorry?

Senator SPECTER. How about prior to May? Have you had in the past referrals to the Department of Justice?

Mr. HAMLIN. The vast majority of them were in the area of education. I can only recall a handful that were not educational matters.

Senator SPECTER. But there had been some other than education?

APPEALS COURT DECISION

Mr. HAMLIN. Yes, there have been. The most recent one was just decided—was a matter involving a hospital in the State of New York that was referred to the Department of Justice about 2 years ago, and there was just a decision last month from the Second Circuit Court of Appeals.

Senator SPECTER. What was the essential question?

Mr. HAMLIN. That was an issue of access to information, where the hospital had denied access to information that we were trying to get after receiving a complaint from a handicapped person that he had been discriminated against because of his handicap.

The hospital declined to give us the information. We referred the matter to the Department of Justice, which sued the hospital. The District Court determined that we should be allowed access, and they were reversed—the District Court judge was reversed by the Second Circuit Court of Appeals.

JUSTICE DEPARTMENT PROSECUTION

Senator SPECTER. Are you saying that it is not possible for the Department of Justice to institute a criminal prosecution in this particular area of civil rights violations?

Mr. HAMLIN. Yes, sir.

Senator SPECTER. There are areas, of course, where Justice does prosecute civil rights matters?

Mr. HAMLIN. If by statute they are authorized—I am not familiar with all the cases handled by the Deparment of Justice—I think in some voting rights case, or if there are cases where the civil rights of persons have been abused by State or local officials, or by private citizens, they have the right to criminally prosecute.

I am not aware of other areas, and surely not unless it is authorized directly by statute.

Senator SPECTER. Wouldn't one of those areas comprise violations within activities of HHS?

Mr. HAMLIN. None that I am aware of. As a matter of fact, I am certain that there are none.

Senator SPECTER. On those situations where matters are referred by your Department to the Department of Justice, does OCR continue to work with Justice on those matters, Mr. Kretchmar?

Mr. KRETCHMAR. Yes, we would.

GAO CONTROL OF INSPECTORS GENERAL

Senator SPECTER. Mr. Mitchell, do you think that the idea which has been advanced by Senator Proxmire has any merit, that the Inspectors General should report to the General Accounting Office? To provide some level of independence for the Inspectors General?

Mr. MITCHELL. No, sir. I do not, because I think that would be a completely different concept than the concept we have now. It is a different concept and might be one that someone would want to consider, but it is certainly not the idea set out in the statute now, nor as I understand the concept, sir.

Senator SPECTER. Well, aside from carrying out the current concept, do you think that the conceptual distinction might have some merit to provide the Inspector General with independence by one of the GAO, as opposed to the Secretary of his own unit?

Mr. MITCHELL. No, sir, I believe the Inspector General is as much or more use to the Secretary than it is to the Congress, sir. The GAO is an independent organization reporting directly to the Congress.

The Secretary, I believe, needs an independent organization within his organization to help him keep an eye on this $200 million Department. But, also, it has a reporting mechanism so that if the opportunity ever came for people to try to suppress anything, then the Inspector General has a way to take care of it.

FLEXTIME

Senator SPECTER. It's been suggested that the Department's policy on employee flextime has resulted in inefficiency. The various agencies require coordination of efforts between a number of individuals. Do you find productivity is decreasing because all persons are not available during the same hours, Ms. Townsend?

Ms. TOWNSEND. Mr. Chairman, there are in most instances requirements for attendance during core hours.

Let's say——

Senator SPECTER. Defined as?

Ms. TOWNSEND. From 10 until 3:30 or 4, people have to be available at those times, except in emergency situations. Flextime right now is not officially in effect in all parts of the Department.

It is being considered in various parts. We have staggered hours throughout the Department: Some offices start at 7:30 or 8, and some start at 9.

And I think——

Senator SPECTER. Is there any flextime at all in the Department?

Ms. TOWNSEND. I believe there is. Perhaps Mr. Itteilag would know more about flextime than I do.

Senator SPECTER. You have been here frequently, but we have not heard from you today.

Mr. ITTEILAG. To the best of my knowledge, the Office of Human Development Services, whose appropriation you have not heard yet, but you will on Friday morning, has a flextime system in use at this time.

Senator SPECTER. Flextime is defined differently from staggered time as giving the individual the choice?

Mr. ITTEILAG. I believe so, sir.

Senator SPECTER. Have your audits revealed anything with respect to lesser use of sick leave and overtime for employees who have switched to flextime?

Mr. MITCHELL. We have not conducted an audit on it, sir. The Department has not yet made their final decision about what it is going to do on flextime. After the Department makes its decision and implements it, then we will conduct an audit and report back.

BLOCK GRANTS

Senator SPECTER. With respect to the current planning or proposals to have block grants, which would consolidate about 40 Federal health and social services programs into just 1 for an administrative unit, what do you think, Ms. Townsend, with respect to giving all of that freedom to State or local governments, as opposed to the way the categories—categorical grants have been set up, to try to make sure that these Federal funds were used for some specific purposes?

Ms. TOWNSEND. The purpose of the block grants is to provide maximum flexibility to the States or localities in devising the programs that fit their needs best. And to require a minimum of Federal strings, if you will.

In exchange for this flexibility and a minimum of Federal strings, States and localities would receive a somewhat smaller total amount in funding than they now get.

Senator SPECTER. What is your thought about that? Good, bad?

Ms. TOWNSEND. I think it's worth a try.

Senator SPECTER. After all, the Federal Government has spent a lot of time, a lot of years devising programs which they think somebody thinks are important.

Now we are going to cut back funding, allow that flexibility, and give the States the authority, cut out the regulatory process.

But it is anybody's guess as to what some governments or some States will do in the way of carrying forward programs heretofore deemed necessary.

Ms. TOWNSEND. I believe that the counterargument to that is that States and localities now bear the burden of providing basic services and protecting our citizens through the provision of the central services.

Now the burden is on them, for the most part, to apply for, and plan for, and manage the moneys they do get, and would continue to get.

We must assume their basic competence and could be prepared to assist them as required.

It would be interesting to look to the past few years to see what the pace of growth in categorical programs has been, but many of the ideas for categorical programs come, after all, from below the State level, where people are feeling needs which they cannot meet, given the current strings attached to programs.

Senator SPECTER. In any of your prior service, have you ever proposed an abolition of the categorical approach to the block or grant approach?

Ms. TOWNSEND. I worked for the Congress at the point when the last block grants were proposed by the administration. So I was not directly involved in their preparation.

FLEXIBILITY IN DECISIONMAKING

Senator SPECTER. One of the things which concerns me is the issue about adhering to the administration's point of view, as opposed to the independence that might be present among very many highly skilled and very intelligent people within the Federal Government.

And do you think that everyone has to pretty much go along with Mr. Stockman and President Reagan and/or if you feel very strongly about something, do you feel there is sufficient flexibility to speak up and say so without impinging on your career?

Ms. TOWNSEND. Let me say this. I accept as a condition of my employment that I must maintain a bottom-line level of adherence to policies and discretion. I feel very few constraints within the Department in terms of making my views known, no constraints at all.

I have put forth my views very strongly to the Under Secretary-Designate and to the Secretary. They know my position on issues and I have worked with them in terms of presentations to OMB.

I feel I have done a good job in that regard. If policies are made and decisions are made that I cannot live with, I should no longer hold this position. I think that is a fair bargain.

COMMENT ON DECISION PROCESS

Senator SPECTER. Is there any avenue for your description, or discussion, or advancing of any different ideas you may have when you come before, say, the Appropriations Subcommittee on HHS, to give us the benefit of the thinking which might not have prevailed with the Secretary or OMB?

Ms. TOWNSEND. I don't believe that that is my role. I believe when I am here I can answer your questions to the best of my ability, and engage in interesting exercises, as we did earlier, about welfare policy. But in terms of explicitly disavowing the administration's policy, I am not prepared to do that.

Senator SPECTER. Well, it wouldn't necessarily be disavowing, it would be suggesting alternatives.

Ms. TOWNSEND. I have my forum to do that. I do it with all the vigor at my command. I hope you believe that. It is true. And I feel that gives me ample opportunity to vent my spleen, my imagination, and all of the other feelings and ideas that I have.

Senator SPECTER. Well, of course, I do believe that. I am just really probing to see what the parameters are. As we subcommittees sit, and listen, and talk and perhaps, jest at times.

We have not given you, Mr. Scully, an opportunity to participate.

Mr. SCULLY. That's fine, Mr. Chairman. [Laughter.]

Mr. ITTEILAG. Senator, I don't mean to be overly procedural, but it would be well for me to comment to you on what the ground rules are, so to speak, with respect to the appearance of witnesses. As with other things we have discussed earlier, the Office of Management and Budget requires witnesses speaking on behalf of appropriations requested by the President to adhere to a certain standard. That standard is to support the budget that is being presented to a congressional committee. When President Reagan's revised budget is presented, witnesses will be required by OMB to support that budget. Witnesses are asked not to volunteer their own personal opinions with respect to any subject, except when they are directly questioned by a Senator, and asked for their personal opinion. It is, therefore, fair to say that if a Senator would like to hear the personal opinion of a witness, they must specifically be asked, keeping in mind again, that this does in certain cases, put administration witnesses in somewhat of a difficult position.

I think it is fair to say, and past experience has shown, that if witnesses are asked their personal opinions, to give their best personal professional judgment, they will in fact do that.

Senator SPECTER. Those are the ground rules which have been established by OMB, not by the Senate, though?

Mr. ITTEILAG. Yes, sir; that is correct. They are established by the Office of Management and Budget, and I believe they are necessary if the President's program is going to be presented in a coherent and logical way.

Senator SPECTER. I just want it to be clear that those ground rules, as you describe them, are rules which apply in the executive branch, as opposed to those agreed to by the legislative branch?

Mr. ITTEILAG. Yes.

Senator SPECTER. Now, Ms. Townsend, having heard that under the direction of OMB, you are directed to respond when asked, will you adhere to that direction, or some other direction from the executive branch?

Ms. TOWNSEND. Yes, sir.

Senator SPECTER. You don't have to answer the question. [Laughter.]

I am at least indebted to you, Mr. Itteilag, for having given me the magic words, personal opinions or personal preferences, so that should Ms. Townsend appear in this forum on some occasion in the future, when we have a relevant budget to consider, more usefully to occupy 2 hours, I will know the magic language.

Mr. Scully, you said you do not mind having been overlooked in the questioning today?

Mr. SCULLY. No, sir.

Senator SPECTER. But I do. Which is your office?

Mr. SCULLY. I am the Budget Officer for the Office of the Secretary. I prepare budgets for general departmental management, civil rights, research and general departmental management. I am here to assist Ms. Townsend primarily.

SUBMITTED QUESTIONS

Senator SPECTER. Does anybody have anything they would like to add? All right. There are quite a number of questions which have not been covered in the course of 2 hours, and I have—we have tried to limit the session to 2 hours.

But there will be some additional questions that we are going to ask you to answer for the record.

And it is our request that answers be provided at the same time that you submit the correcvted hearing transcript.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

UNRESOLVED AUDITS IN HHS

Questions have been raised in the past about the numbers of unresolved audits in HHS. As recently as 1979, the Inspector General of HHS testified that more than 50% of the audits are unresolved at any given time and that in March of that year 2,259 audits were unresolved.

Question: What steps has the Inspector General taken during the last two years to reduce the number and percentage of unresolved audits?

Answer: During the last two years, the Department issued the first comprehensive departmental policy on audit resolution. This policy and accompanying procedures implement the requirements of OMB Circular A-73, and provide detailed instructions for resolving audit findings from the receipt of an audit report to final resolution. The policy and other steps taken provide for:

- A six month standard for making final determinations;
- Periodic reporting by the awarding agencies to the Inspector General on the status of significant reports open for more than six months;
- Quarterly reporting by the Inspector General to the Secretary on the audit resolution performance of the Department, including measurements against the six month standard;
- Follow-up audits by the Audit Agency of the Department's grantees/contractors, who have worked with the Department to correct system deficiencies cited in audit reports;
- A requirement that HHS Principal Operating Components have General Counsel concurrence on any disagreement with an audit recommendation based on a difference in interpretation of a law, rule, or regulation used by the auditor to support the recommendation;
- The establishment of an Audit Resolution Council composed of the Under Secretary, two Deputy Under Secretaries, the Assistant Secretary for Management and Budget, the General Counsel, and the Inspector General to:
    - Review and make recommendations for the resolution of audit findings over $250,000 that have not been resolved within six months;
    - Monitor ongoing POC audit resolution performance;
    - Consider and recommend sanctions against grantees/contractors who fail to correct deficiencies cited in audit reports.
- A requirement for approval by high level POC officials of all audit resolutions;

- A goal that POCs reduce their backlog of audit reports to zero by September 30, 1981;
- The elevation of resolution responsibility for monetary findings cross-cutting HHS agencies or involving more than our Department to the Office of the Secretary level;
- A requirement that interest be charged on disallowances which are not repaid within 30 days of an action official's determination letter.

Question: What is the current number and percentage of unresolved audits?

Answer: On December 31, 1980, the number of unresolved audits and the percentage of those unresolved audits more than six months old was:

Under Six Months Old	Over Six Months Old	Total
896	908	1804
50%	50%	100%

While the percentage of unresolved audit reports has not changed from the percentage cited by the Inspector General's 1979 testimony, the Department has made a significant reduction since 1979 in resolving the monetary findings outstanding. Those reductions are reflected in our responses to the other questions raised on unresolved audits in HHS.

Question: What is the estimated monetary amount involved in these unresolved audits?

Answer: On December 31, 1980, the amounts (in millions) associated with unresolved audit reports were:

Over Six Months				
Questioned Costs of $250,000 or More	Questioned Costs of Less Than $250,000	Sub-Total	Under Six Months	Total
$13.5	$25.0	$38.5	$31.3	$69.8

Question: What are your plans for rapidly concluding unresolved audits?

Answer: The policy initiatives and steps cited earlier should enable us to rapidly conclude unresolved audits. The Department's efforts have already produced a marked decrease in unresolved monetary amounts over six months old as the table below illustrates.

Quarter Ending (excl. Education Division)	No. of Unresolved Audit Reports Over Six Months Old	Unresolved Monetary Amounts (Millions)
12/31/79	821	$105.8
3/31/80	802	77.8
6/30/80	758	46.1
9/30/80	1,022	52.5
12/31/80	908	38.5

Within the above reports and amounts the Department has also signficantly reduced the unresolved monetary reports over 6 months old with findings over $250,000.

Quarter Ending	No. of Unresolved Audit Reports With Monetary Findings Over $250,000	Unresolved Monetary Findings Over $250,000 (Millions)
12/31/79	29	$68.4
3/31/80	27	56.2
6/30/80	22	23.5
9/30/80	11	12.9
12/31/80	15	13.5

DHHS WORKFORCE

Question: What is the composition of the DHHS workforce in terms of Handicapped individuals, Women, Blacks, Hispanics, Native Americans, Orientals and the Aged?

Answer: The composition of the DHHS workforce of 162,723 active employees as of October 1980 is as follows:

Minorities (Men & Women)		
Blacks	36,132	22.2%
Hispanics	6,031	3.7%
Native Americans	7,223	4.4%
Orientals	2,250	1.4%
All Other (Men & Women)	111,087	68.3%
Total	162,723	100.0%
(All Women)	(99,912)	(61.5%)
(All Handicapped)	(6,236)	(3.84%)

Question: For each of the above groups, identify the percentages of individuals in clerical, technical, and administrative positions, and identify any shifts between those areas in the last year.

Answer: The information requested is not routinely kept in standard personnel reports. It is being compiled and will be forwarded by March 20. This information will also include the data on aged employees as requested above.

DHHS WORKFORCE MINORITIES

Question: How have minorities fared in the percentages of promotions in the HHS workforce during the last year?

Answer: The percentage of minorities and women receiving promotions in GS grades 1 through 15 out of the 16,835 promotions awarded for the period April through September 1980 is as follows:

Minorities (Men & women)	Promotions	% of Promotions
Blacks	4,084	24.2%
Hispanics	1,008	5.9%
Native Americans	56	.3%
Orientals	237	1.4%
All Women	12,500	74.2%
All Handicapped	130	.7%

A breakdown of promotions for minorities and women for the period October 1980 through March 1981 will be provided as soon as it becomes available, in about three weeks.

FLEXITIME

Question: What have been the advantages of employee flexitime?

Answer: Our reviews of flexitime have indicated that several advantages have resulted from its use. Most participating organizations in the Department have reported increased employee morale and job satisfaction. Other advantages are:

- the virtual elimination of tardiness:
- a reduction in short-term leave usage; and
- a reduction in transportation costs for some employees who were able to shift from private to public transportation.

Question: What have been the disadvantages of allowing employee flexitime?

Answer: The disadvantages of flexitime are as follows:

- additional recordkeeping is required to maintain an accurate account of the varied working hours of employees;

- abuses in reporting working time have been reported on the part of some employees; and

- in some cases supervisors have encountered problems in planning and scheduling work due to the varied work schedules of employees.

Question: Do you intend to maintain this worktime policy indefinitely, or is it still in an experimental stage? What are your plans?

Answer: This policy is still in an experimental stage. Public Law 95-390 authorized a three-year period of controlled experimentation with the use of flexible and compressed work schedules beginning in March of 1979. The law requires the Office of Personnel Management (OPM) to submit a report in October 1981 to the President and to the Congress on the results of the Government-wide experimental program. This report must include recommendations on whether to modify pertinent laws to permit permanent use of flexitime. The report will be based on data obtained from the study and evaluation of experiments throughout the Government. Several components and offices of this Department are included in OPM's four types of studies, i.e., a longitudinal and cross-sectional study; narrative evaluation reports; on-site studies; and a special study on the net energy impact of the schedules. Once the OPM report has been completed, Secretary Schweiker will decide whether to continue the flexitime policy.

BLOCK GRANTS

Question: The introduction of block grants as proposed would consolidate the management of about 40 Federal health and social services programs into just one or more administrative units. To what extent do you expect block grants to result in less money being lost due to mismanagement, inefficiency and systems problems? The Inspector General apparently believes these losses to be quite sizeable.

Answer: We agree with the Inspector General. There are three primary areas of savings that will be realized under the block grants: reductions in Federal staffing; administrative savings at the State and local level due to eliminating the complexity of dealing with 40 separate Federal programs; and the benefits of more effective targeting of resources to people in need.

Question: The programs proposed for block grants are purported to overlap and duplicate other programs in services provided and/or populations served. Do you agree? Can you provide us with some examples?

Answer: This matter will be addressed in the appropriations justifications and other supporting material to be released after March 10 in conjunction with the revised President's budget.

Question: To what extent would block grants make services provided more accessible to individuals in need?

Answer: This matter will be addressed in the appropriations justifications and other supporting material to be released after March 10 in conjunction with the revised President's budget.

Question: What controls would be needed in block grants to protect against civil rights and financial abuses?

Answer: This matter will be addressed in the appropriations justifications and other supporting material to be released after March 10 in conjunction with the revised President's budget.

TRAVEL

Question: Last fall, legislation was passed requiring the General Services Administration to make an agency-by-agency analysis of travel by Government employees. A partial report recently revealed that Government travel spending runs about $3 billion a year. How many annual trips per capita are made per year by Department of Health and Human Services employees?

Answer: We have not kept our records in a way that enables us to determine the exact number of trips taken. However, based on a voucher sample provided to the OMB Interagency Travel Management Improvement Project they estimated we had 568,330 trips including local trips, in fiscal year 1979. This would equate to 4.03 trips per person. There is no separate estimate for local trips.

Question: How does the Department's average length of trip, in days, compare to the government-wide average of 8.8?

Answer: Based on our input to the OMB study the Department's average length of trip was calculated to be 4.76 days.

Question: What is the average cost of trips made by Department employees?

Answer: The average cost is $166, including local trips.

Question: What is the actual average cost per trip? The government-wide average is $176.

Answer: Based on our input to this study the Department's average cost per trip was calculated to be $166.

Question: What percentage of your trips accounts for:
- operational or managerial activities?
- travel for training?
- informational meetings?
- conferences?
- speeches or presentation?
- special mission travel?
- relocation of employees?
- unknown reasons (blanket authority to employees)?

Answer: Based on the voucher sample we provided to the OMB Interagency Travel Management Improvement Project the percentage of trips was calculated as:

- operational or managerial activities	32.2%
- travel for training	9.1%
- informational meetings	22.4%
- conferences	8.9%
- speeches or presentation	2.2%
- special mission travel	1.6%
- relocation of employees	1.4%
- unknown reasons	22.2%

Question: Does the Department have an Office of Travel Management? Do the agencies have Offices of Travel Management? Can these be eliminated without impairing your efficiency?

Answer: The Department does not have an Office of Travel Management. However, we have a departmental unit which is responsible for developing and promulgating travel policy and procedures. The agencies do not have Offices of Travel Management. They do have staff which deal with the departmental staff concerning travel policy. These positions cannot be eliminated as they are essential to the process of developing, promulgating and implementing travel policy.

Question. Can you prepare for the record a tabulation of travel expenses for all recipients of HHS grants and contracts?

Answer: We have never compiled these data and therefore cannot provide them for the record. Accounting data for grants and contracts rarely show travel expenditures as a separate cost. Such an undertaking would be immense and would impose a paperwork burden on grantees and contractors.

Question: A great deal of information now obtained by travel could be obtained more cheaply through other means. What has the Department done to encourage the use of conference calls, the exchange of videos, the use of telecopiers, and exchange of information by mail, as alternatives to travel?

Answer: The Department of Health and Human Services (HHS) has focused attention on reducing travel expenses through controlling travel budgets and substituting alternative forms of communication. This has resulted in a projected 10% decrease in FY 1981 travel expenditures (over FY 1980 levels) despite an approximate 10 to 15% inflationary growth in travel costs (e.g., fares, per diem, lodging). The specific impact of alternative forms of communication upon HHS travel expenditures is unknown. In general, HHS makes use of telecopiers, word processors, videotape exchanges, conference calls, and mail where these vehicles are cost effective. As an example, the National Institutes of Health installed a telecommunications line between two widely-separated units and used the line to conduct scientific, educational, and training seminars and bi-weekly directors conferences. This use of new technology resulted in avoiding $55,200 in annual travel and toll costs. The control over travel budgets also forces all levels of management to evaluate the justifications for each proposed trip in light of ceilings on total travel allowances.

Question: Are the same travel savings being encouraged for HHS grantees and contractors?

Answer: The Department has not issued a policy or guidelines to grantees and contractors specifically encouraging them to reduce travel expenditures. For grants, the Office of Management and Budget has ruled that the Department is not to request information on grantee travel. This was done to reduce reporting requirements and ease the paperwork burden on grantees. However, grants management officers negotiate grant project budgets according to general departmental instructions, to eliminate unnecessary expenditures and reduce costs, of which travel is one component.

While there have been no instructions for contractors, several factors do limit travel:

- Decreasing funds for contracts acts as a curb on travel
- Agencies frequently seek firms with employees in several sites, or access to employees in several sites
- Competition among contractors leads to lower travel costs
- In reviewing proposed contracts, departmental staff seek ways to lower travel costs (e.g., reducing the number of trips specified, reducing the number of people traveling to each site, reducing the number of sites or pairing sites).

GRANTS AND AWARDS MISUSE

Question: HHS administers some 825,000 grants and awards each year. Concern has been raised about these awards being issued to individuals or firms which have misused government funds resulting in investigations into their conduct.

To what extent has the Inspector General of HHS been able to identify and keep track of those who misuse HHS grants and awards?

Answer: The following table shows the Office of Investigations workload in this area:

	1977	1978	1979	1980
Number of Grantee and Contractor cases under investigation at the end of the year.	76	74	64	73
Number of convictions during the year.	7	22	5	20

When these and other matters are closed, they are referred to the Principal Operating Components of HHS for administrative action. The Office of Inspector General is now initiating procedures to track the handling of these matters by the Principal Operating Components. In addition, we will insist that they levy appropriate administrative sanctions. Finally, based upon special agent and auditor findings, reports of observations are prepared in order to close gaps and loopholes, which predispose HHS to fraud and abuse in this area.

Question: What actions has the Department taken to keep individuals and companies under suspicion of misusing government funds from getting new awards until their old cases are cleared up?

Answer: On November 10, 1980 the Department issued a regulation entitled: "Debarment and Suspension from Eligibility for Financial Assistance". This regulation established guidelines and procedures for suspending and debarring individuals, institutions and business entities from participation in departmental discretionary grant programs upon showing that the person or institution was guilty of fraud or abuse in the conduct of their business with the government. Similar regulations have been published for debarments in connection with contracts.

The suspension and debarment regulations were published in 45 FR 67262 (dated October 9, 1980). Under these regulations, the Secretary may suspend a person or organization from participation in departmental programs when (s)he "believes that grounds for debarment exist." Suspension is immediate, and lasts until full debarment proceedings are completed. If the problems are not sufficiently serious to warrant a suspension or debarment, the Department could take less severe action, such as greater monitoring of the programs, special restrictions or controls, more frequent or detailed financial reporting, etc. In order to fully inform appropriate officials of the status of program participants who have come to the attention of OIG, this office prepares an Advice of Scheduled Investigation (ASI) form when a case is opened, and provides a copy of the final investigative report to the program officials when an investigation is completed. The ASI advises the program officials that an investigation of a person or institution has been initiated, and what the allegations are against them. The investigative report provides information as to the evidence which supports or denies the allegations, and also any prosecutive action taken by the Department of Justice in the case.

Question: Is this type of problem more common to particular programs or is it manifested relatively equally through all grant programs?

Answer: We have found similar problems within most HHS programs. However, we think several agencies have made greater progress in remedying them than others have.

MONEY IMPROPERLY SPENT BY GRANTEES

Question: In May of 1979, the Inspector General made several recommendations on ways to resolve audit findings more rapidly. One recommendation called for charging interest on money improperly spent by grantees--that is, treat the misused grant as though it was a loan from the Federal government. What is the status of this recommendation?

Answer: The Department issued a comprehensive policy on the resolution of audit findings last July which provides basic standards and detailed procedures for resolving all audit findings on grant and contract programs. This policy includes a provision which requires that interest be charged on disallowances which are not repaid within a certain period of time (usually 30 days) after a grantee or contractor is notified of the disallowance by the responsible audit resolution official. Although this requirement does not go quite as far as the Inspector General's recommendation, we believe that it will result in improvements by encouraging prompt repayment of disallowances and discouraging grantees and contractors from making "frivolous" appeals to delay the resolution process. The Department's Principal Operating Components have implemented, or are currently in the process of implementing, the requirement (including changes to regulations, where necessary).

Question: If it is being implemented, how much money has been collected in interest thus far, and how much of the "principal" has been returned?

Answer: To date POCs are not making interest collections but the procedures are in the process of being implemented. Collections of principal amounts are as follows:

	In Millions
FY 1979	$61.1
FY 1980	$49.6
1st Qtr. FY 1981	$ 2.3

Question: As implemented, is the returned money, plus interest to be returned to the agency from which it was distributed, and to be awarded to another grantee?

Answer: The principal is returned to the appropriation from which it was disbursed. It may be reused only if the appropriation is still available for obligation. The interest is deposited to the Miscellaneous Receipt Account in the Treasury Department since it is not available for use by the Department.

Question: What happens to the money that is recouped from misused grants? Who gets the interest?

Answer: The answer is basically the same as stated above. The principal is returned to the appropriation from which it was disbursed while the interest goes to the Treasury Department.

Question: In November of 1979, GAO published a report titled "Health Costs Can Be Reduced by Millions of Dollars if Federal Agencies Fully Carry Out GAO Recommendations." Of the 262 cost-saving recommendations that GAO made to the Congress in this report, how many recommendations have been put into effect, and what savings have been resulted? Are any of the other cost-saving recommendations proposed for implementation? If so, which recommendations, and when? What recommendations did you not adopt?

Answer: The Department reported to the Senate Committee on Appropriations on the status of the GAO recommendations involving programs managed by this Department. That report was transmitted to the Chairman and to the Ranking Minority Member on April 7, 1980. The status of each GAO recommendation was discussed in that report. Those recommendations with significant cost-savings potential had been already incorporated into the Department's FY 1980 and FY 1981 program initiatives. Other recommendations were directed to the Department of Defense, to the Veterans Administration, or to State governments. The remaining recommendations have been implemented by the Department or have been discussed in the report of April 7, 1980 as exceptions with explanations of the Department's position.

CONSULTANT SERVICES

Question: What percentage of DHHS's budget pays for consultants?

Answer: Less than half of one percent of the Department's budget is used to pay for the services of consultants.

Question: What percentage of consultants are contracted due to insufficient in-house expertise? In-house capability?

Answer: An examination of a sample of the non-evaluation contracts reviewed by the Assistant Secretary for Management and Budget indicates that over 90 percent of the contracts were awarded to provide expertise or capabilities not otherwise available. The contracts can be roughly divided equally between those seeking expertise and those seeking capability. The remaining 10 percent included services which by statute must be performed by consultants, and services the Department cannot provide itself, such as testing approaches in an educational setting.

The expertise contracted was for specialists with particular knowledge or abilities required under specified circumstances such as conferences to gain state-of-the-art information. The capabilities contracted for were to provide numbers of people working in concentrated periods of time, largely on one-time efforts, for which it would be inefficient to hire permanent staff. Both are fully justified uses of consultant services and the most typical uses of consultants.

Question: What would be the consequence of freezing all consulting contracts pending a full review of their usefulness?

Answer: The Department already subjects all consulting services contracts to a series of full reviews of their usefulness. We have established policies and procedures requiring different levels of review and approval, which escalate as the contracts' costs increase. In addition, departmental components must receive the approval of the Assistant Secretary for Planning and Evaluation for virtually all program evaluation contracts, and the approval of the Assistant Secretary for Management and Budget for other consulting services contracts over $100,000. These policies and procedures, coupled with absolute expenditure ceilings, concentrate our resources on useful contracts.

A freeze on actual awards would have the following effects:

- Because of the lead time necessary in contract awards (up to nine months), delaying contract awards would interfere with recently instituted departmental planning to insure even distribution of contracts throughout the year and to prevent large numbers of awards, hastily made, in the last quarter of the fiscal year. This problem was the subject of a recent GAO study, which was critical of the Department's planning and management of contracts.

- A freeze on program evaluation contracts would cut off the supply of new, objective knowledge on program effectiveness and efficiency and would inhibit the Department's ability to make informed budget and program operation decisions.

- A freeze on non-evaluation contracts would interrupt some programs already underway, probably resulting in increased costs or decreased usefulness when the projects are eventually reinstituted.

Question: Do you have any plans to implement delay-of-drawdown letter of credit financing, or checks-paid financing for consultant contracts?

Answer: No. These kinds of contracts are customarily paid on a reimbursable basis with relatively few exceptions. The process followed is that the consultant contractor performs the services required by the contract and then submits an invoice for payments. The contractor is normally paid by Treasury check. There is no advance funding by letter of credit and therefore no opportunity for delay-of-drawdown financing or checks-paid financing.

Question: How much money in interest not earned will DHHS lose during Fiscal Years 1981 and 1982 as a result of not using these finance methods?

Answer: None, because contracts are paid on a reimbursable basis.

FREEDOM OF INFORMATION ACT

Question: A great number of Freedom of Information Act requests come from businesses and corporations seeking information about competitors. Provisions of the Act are meant to prevent such "industrial espionage." To what extent are these types of requests a problem at HHS?

Answer: Freedom of Information requests for contract and related materials are a problem in the Department only to the extent that such requests sometimes involve considerable amounts of paper. We have established procedures for the processing of such requests, and we work closely with the Office of General Counsel on these matters.

Question: Are the provisions of the Freedom of Information Act adequate to prevent the improper disclosure of confidential business information or trade secrets?

Answer: The provisions in the Freedom of Information Act and our implementing regulation, coupled with court decisions, other statutes and our own procedures, are adequate to protect proprietary business information.

Question: Would you comment on the following innovations for Freedom of Information Act funding? Having a line item for FOI/Privacy Act operations?

Answer: Since the total cost of administering these and other statutes concerning information access is relatively small and this Department treats the program with high priority, we do not believe a line item in the budget is necessary.

Question: Having a set fee for all FOI Act requests, which would be returned only if no records resulted from the request?

Answer: Establishing a set fee for all requests made under the Freedom of Information Act would be contrary to one of the main principles of the Act which is that information be made available to the public. It would provide an advantage to entrepreneurial requesters such as law firms and corporations which have relatively large resources but it would be a disadvantage for individual members of the public and public interest groups which have relatively limited resources.

Question: Having all fees collected from FOI Act requests returned to the departments and agencies setting such fees?

Answer: There are arguments for and against returning Freedom of Information fees to the involved departments and agencies. In these days of tight budgets, returning the fees would be of some help. However, the help probably would be small in most instances because experience has shown that the fees collected actually account for only ten percent of the costs of administering the Act. Also, such a turn-back provision could encourage agencies to charge unwarranted fees. On balance, we believe the present system which sends funds to the Treasury is appropriate.

INSPECTOR GENERAL DISMISSAL

Question: Effective January 20, 1981, President Reagan dismissed 14 Inspectors General Government-wide, including the Acting Inspector General in HHS.

Has the dismissed Inspector General continued to participate in any on-going investigations, as the President's dismissal order permitted; and if so, which ones?

Answer: Yes. Richard Lowe was not only Acting Inspector General of the Department of Health and Human Services, but he was also Deputy Inspector General. As such, he had been actively involved in several investigations and audits.

At the time of his termination, Mr. Lowe was participating in the investigation and audit of an End Stage Renal Dialysis facility. In addition, Mr. Lowe directed in January that the Division of Special Assignments should be a part of and report to the Assistant Inspector General for Investigations. To assure that this process was completed in an efficient manner, it was necessary to have Mr. Lowe available for consultation. Also, Mr. Lowe was involved with the design of an investigative project dealing with hospital costs and was needed to assure effective implementation of task.

Mr. Lowe was participating in the planning and development of the fourth Annual Inspector General report to Congress which covers calendar year 1980 when he was the Acting IG.

Question: Who is being considered for the position of permanent Inspector General, and what selection process is being used?

Answer: The Office of Personnel at the White House, working with Secretary Schweiker and his staff, has a number of candidates under consideration.

Question: How long does the Department anticipate a vacancy in the permanent Inspector General's position?

Answer: It is our understanding that the new Administration is attempting to fill the Inspector General's position on a high priority basis. We expect that a Deputy will be nominated subsequent to the Senate confirmation of the Inspector General.

Question: To what extent does the dismissal of Inspectors General politicize their offices when the Inspector General Law sought to keep them immune from politics?

Answer: As Chief Executive of the Executive Branch, the President is responsible for its overall management. As such, it is within the President's powers to select for term appointments those individuals he believes will assist him in managing the Executive Branch in accord with his philosophy and policies.

CALENDAR 1980 REPORT - ABUSES

Question: The Inspector General for HHS is required to report annually to Congress (not later than March 31) summarizing the activities of the Office during the preceding calendar year.

Is the calendar year 1980 report available at this time; or if not, can you highlight some of the Office's major activities and accomplishments during the preceding calendar year?

Answer: The calendar year 1980 report will not be available until April 1, 1981. Among the 1980 accomplishments:

Audit Highlights: The Audit staff continued to achieve a high degree of productivity. During the calendar year the auditors released 3,882 reports; another 1,323 audit reports were performed for other Federal agencies by our auditors. OIG auditors prepared 1,124 reports and 2,758 reports were prepared for us by public accountants and State auditors. During the calendar year, $80 million was recommended for financial adjustments. More importantly, over $126 million in previously recommended financial adjustments were concurred in by responsible program officials last year.

During 1980 we were able to institute an experimental effort to begin on-line audits. These audits occur as the transactions are actually taking place instead of some months or years after they are completed. This on-line concept allows us to recommend immediate accounting and management changes at the institution audited, and to give technical assistance before any problem discovered mounts up into a substantial financial adjustment.

Investigative Highlights: The Office of Investigations continued to improve its staff productivity in 1980. With a minus 8 percent change in its workforce by the end of 1980, there were 148 convictions and $4.7 million identified for recoveries, fines and restitutions. The investigative workload continues to grow at a greater rate than the workforce. Our subpoena power continues to be a valuable audit and investigative tool. We issued 28 subpoenas in 1980.

The Division of State Fraud Control has major responsibility for administering grants to support State Medicaid Fraud Control Units. These units have the principal authority for detecting and prosecuting Medicaid fraud within their respective States. The division assisted and certified 30 States by the end of 1980. At the close of the year, the State units had achieved over 366 indictments and 196 convictions for Medicaid fraud. The units resulted in over $19.5 million in fines, overpayments and recoveries during calendar year 1980.

Question: To what extent have you found high-paid and other employees sitting around with no work to do? What are you doing about this?

Answer: One documented case concerning such an allegation involves an employee, in one of our regional offices. The former employee was convicted of knowingly converting to his own use the services of his secretary to type documents for his personal business during duty hours, without reimbursing the United States for the value of her services. Subsequent to this jury verdict, the judge set aside the conviction on the grounds of "lack of criminal intent." However, during the trial the employee raised the defense that this was done when he and his secretary had no official work to do. Testimony at the trial indicated that not only was the employee's unit assigned duties in the Headquarter's work plan, but that he refused work when asked by his Principal Regional Official, stating that he and his staff were too busy.

There is no indication that the questioned activity occurs to any great extent. This office has established a hotline to receive such complaints. These complaints, whether through the hotline or by other sources, are thoroughly investigated if the sources provide enough information to proceed. When warranted, these investigations are conducted in cooperation with the other IG components, Audit Agency and Health Care and Systems Review. If these investigations indicate a criminally prosecutable charge against a government employee, the findings are presented to the U.S. Attorney. Non-criminal cases are reported to the appropriate departmental operating component for administrative action.

Question: What have you found in regard to abuse of employee travel?

Answer: During Calendar Year 1980, OI continued to investigate allegations of employee travel voucher fraud. Most of these cases involved the submission of fraudulent expense claims and/or fictitious receipts. Several employees were convicted for individual attempts to defraud the government. Additional cases were declined by the U.S. Attorney and subsequently referred to the Principal Operating Components for administrative action.

These frauds have been uncovered by Hotline referrals, routine audits, and complaints. Generally, this type of fraud involves only one individual acting on his own, and the amounts of fraud are relatively small.

The Audit Division of the Inspector General's office has not examined recently the issue of employee travel. However, the Washington Area Audit Office of the IG's Audit Division presently has an audit underway which is looking into the travel issue regarding employees of the Office of the Secretary and the Office of Human Development Services.

Question: Have any investigations regarding consultant and grantee travel expenses been initiated? If so, what are your findings and recommendations?

Answer: Generally, investigations and/or audits of consultants or grantees' travel expenses are tangential to an investigation or audit of more serious allegations of fraud or abuse. It has been our experience that if the initial allegations of fraud are confirmed, travel cheating should be anticipated. In most instances, the travel frauds have been the lesser counts in the indictments but serve, during trial, to further discredit the defendant.

The Inspector General recommends that consultants and grantees be required to conform to Federal travel regulations, requirements, and reimbursement schedules.

COMPLIANCE WITH THE GENERAL ACCOUNTING OFFICE ACT OF 1980

Question: The General Accounting Office Act of 1980, requires the Inspector General of HHS to conform to certain of the same provisions of the Act applicable to IGs in other agencies. Two of those provisions stipulate that (1) the Inspector General should comply with standards established by the Comptroller General for audits of Federal establishments, organizations, programs, activities, and functions; and (2) the Inspector General should report expeditiously to the Attorney General whenever the Inspector General has reasonable grounds to believe there has been a violation of Federal criminal law.

Had the Inspector General for HHS already complied with relevant GAO standards in conducting or authorizing audits before passage of the 1980 GAO law?

Answer: Yes the Inspector General had already complied with relevant GAO standards in conducting or authorizing audits before passage of the 1980 GAO law.

Question: If not, did this enactment standardize Inspector General-initiated audits or are there any on-going audits that yet do not comply with the GAO standards?

Answer: This was answered in the question above.

Question: In which specific instances did the Inspector General report to the Attorney General concerning suspected criminal violations and what action (that is, further investigation, indictment, prosecution, settlement) did the Justice Department take?

Answer: Even prior to the passage of the General Accounting Office Act of 1980, the Office of Investigations (OI) referred potential criminal violations to the appropriate U.S. Attorney's office. This practice continues. In FY 1980, OI presented 119 cases to U.S. Attorneys for prosecutive opinions and action. During the same period, based upon OI criminal investigations, 137 individuals were indicted, and 145 individuals were convicted. As a result, $599,133 in fines were levied, and $2,537,188 in restitution was ordered by the courts.

It should be noted that OI was the sole or principal criminal investigative agency involved in the cases cited above. Additionally, after a case has been presented for prosecutive action, OI has always been available to conduct any further investigation requested by a U.S. Attorney.

In a broader sense, OI also has a good working relationship with the Department of Justice investigative agencies. Occasionally, if a particular situation indicates that an investigation could be better handled by the Department of Justice, OI will refer the matter to the appropriate agency.

Question: Does the Inspector General for HHS or the Secretary of the Department think that the Justice Department follow-up was sufficient and appropriate or are there questions about the disposition of these matters?

Answer: In FY 1980, as in prior years, the Justice Department responded in a very positive manner to cases OI referred to U.S.

Attorneys for prosecutorial consideration. Typically, OI establishes contact with U.S. Attorneys at an early stage in the investigative process. This collaborative approach tends to maximize the time and effort of prosecutors and investigators alike. This is particularly important in view of OI's high caseload and relatively modest number of investigators. Cases promising little prosecution potential or program impact are disposed of quickly so that quality cases can receive emphasis in terms of attention and resources, in both OI and the Justice Department. For example, in FY 1980, of the 34 health care cases that were referred to prosecutors and declined for prosecution for various reasons (e.g., low dollar amounts, unavailable witnesses, clouded issues or lack of available proof, etc.), 31 were declined in the same month as the referrals were made, thus quickly freeing staff for work on more significant cases.

In some instances, U.S. Attorney's offices have worked concurrently with OI on cases taking several years of development in the field and in grand juries. A number of U.S. Attorneys have developed and maintained a keen interest in OI cases and have expressed interest in, and concern for, the results of administrative actions taken by HHS program agencies as a result of OI investigations. Their personal interest in our cases and our agency is both productive and extremely gratifying.

Overall, we believe that the Justice Department's handling of OI cases at all levels has been equitable and directed to appropriate interests of justice, economy, and efficiency.

MEDICARE AND MEDICAID FRAUD AND ABUSE

Question: During Fiscal Years 1980 and 1981, an extensive criminal investigation of Medicare and Medicaid fraud and abuse has been undertaken by the FBI.

What involvement has the Inspector General for HHS had in the conduct of that investigation, especially in terms of initiating suspect lists or providing data and information to the FBI?

Answer: The FBI's case was based primarily upon information supplied by a laboratory operator. OIG personnel had been instrumental in arranging for that laboratory's cooperation with the FBI. Subsequently, the OIG cooperated extensively with the FBI investigation on related matters. The Audit Agency reviewed three laboratories associated with specific allegations, and identified overpayments of approximately $1.8 million. In addition, briefings, working papers and other information on certain laboratories were provided to the FBI. One audit was conducted specifically at the request of the Department of Justice.

Question: What units in HHS are charged with investigations of fraud and abuse under Medicare and Medicaid?

Answer: The units within HHS that are charged with investigations of fraud and abuse under Medicare and Medicaid are the Office of Inspector General and the Health Care Financing Administration (HCFA)Bureau of Quality Control. Other entities within HCFA having additional responsibilities for insuring appropriateness of Medicare and Medicaid payments and collection of overpayments are:

Bureau of Program Operations; Bureau of Program Policy; Bureau of Support Services; Office of Management and Budget; and the ten HCFA Regional Offices.

In addition to these HHS entities there are various State and private units which are funded by HHS and which are charged with investigations of fraud and abuse under Medicare and Medicaid. These units include the State Medicaid Fraud Control Units and the State Utilization Review units. In addition, the carriers and intermediaries which act as agents of HHS in administering the Medicare and Medicaid programs have definite responsibilities in the detection of fraud and abuse.

Question: How are the activities of each of these entities coordinated?

Answer: It is the policy and practice of OIG to utilize not only its own resources, but also those of other HHS components, in a unified approach to curb fraud and abuse in HHS programs, including Medicare and Medicaid. Thus, besides interaction between the several OIG components on these matters, we draw various components of HCFA into the scheme of things as partners in this effort.

OI personnel have easy and routine access to HCFA, and frequent contact, at the Regional Office level. HCFA, in its administration of health care programs, refers matters requiring criminal investigation to OI officials at the regional level. These matters are initially developed by HCFA, or the health care intermediaries or carriers, or by Medicaid State agencies. OI routinely notifies HCFA Headquarters and/or Regional Offices of investigative results so that HCFA can determine appropriate administrative action to be taken concerning health care providers and practitioners.

OI, Audit Agency, and HCFA have worked jointly on several projects of national scope, notably Project Integrity I (computerized review of Medicaid billings to detect fraud and abuse) and on Home Health Care agencies.

OI has established at Headquarters the position of program inspector for Medicaid, Medicare, and other HCFA programs. The incumbent inspector coordinates OI investigations nationwide regarding HCFA programs, and maintains personal contact with HCFA personnel at their central office and with OI personnel in the field to ensure an easy and efficient flow of information and assistance in this regard. The HCFA efforts in detecting fraud and abuse, and OI efforts in investigating fraud and other crimes associated with Medicaid and Medicare, are coordinated at both the Regional and national levels.

Question: What savings have been achieved by each of these entities as a result of their anti-fraud and abuse efforts in the past year?

Answer: During calendar year 1980 the Inspector General's Office has identified savings in the Medicare and Medicaid programs in the amount of approximately $77.5 million. These savings are in the form of audit findings, fines, recoveries and restitution.

An addition, the Bureau of Quality Control of HCFA has identified the following approximate savings and/or overpayments as a result of their efforts for fiscal year 1980 in the following areas:

Abuse Reviews, $66.0 million;
Sanctions, $4.8 million; and
Validation Reviews, $145.0 million.

STATE MEDICAID FRAUD CONTROL UNITS

Question: How are the activities of these units coordinated with those of the State Medicaid Fraud Control Units?

Answer: The State Medicaid Fraud Control Units are state operated entities whose principal function is the investigation and criminal prosecution of Medicaid providers who defraud the Medicaid program, or who abuse, neglect, or defraud patients of nursing homes or other health care facilities receiving Medicaid funds. OIG is responsible for the certification, recertification, and funding of these units and works closely with the units to insure both that they are effective in fulfilling their functions, and that they cooperate effectively with Federal officials in relevant areas.

For example, the same provider may be defrauding both Medicare and Medicaid and, depending upon circumstances, either the unit, OI or another Federal investigative agency may become the lead agency. They may work the case jointly, or each may take responsibility for its relevant part of the charges, keeping the other apprised of its activities and results. The unit directors and their Federal counterparts in the field are responsible for this day-to-day coordination.

The OIG, Division of State Fraud Control reviews unit coordination activity as a part of routine recertification reviews. It also participates with OI, FBI, and the Criminal Division, Department of Justice in resolution of general policy problems and investigative coordination in particular situations. A recent national conference of leaders from OIG, FBI, the Criminal Division of the Department of Justice, and the units was held to improve and expand on the current methods of cooperation and to consider special joint task forces for health care fraud in selected cities.

DEPARTMENT OF JUSTICE COORDINATION ACTIVITIES

Question: What specific actions are you taking to insure that the Department of Justice is provided information on potential fraud?

Answer: When information is received alleging a fraud in an HHS program, a preliminary investigation is conducted to determine the validity of the allegation. Upon determination that fraud is likely to exist the United States Attorney's Office of that jurisdiction is conferred with and advised of the identity of the subject, the potential scope of investigation, and possible results. The Assistant United States Attorney (AUSA) assigned then directs the full scale investigation.

Upon completion of the investigation, OI prepares a Report of Investigation for the AUSA to assist his indictment and trial preparation. In addition, a White Collar Crime Referral Form is prepared and submitted to the Department of Justice.

Question: What has impeded this activity in the past and have these problems been overcome?

Answer: This agency has not experienced any difficulties providing the Department of Justice with information concerning potential fraud.

As previously reported, OI Special Agents advise the United States Attorney's Office early on when a full scale investigation is contemplated.

In addition, OI Special Agents are involved in the Department of Justice White Collar Crime Task Forces in various parts of the country. Close liaison is also maintained with the Department of Justice Economic Crime Unit prosecutors assigned to the various jurisdictions.

Question: In addition to reforms, such as making fraud a felony instead of a misdemeanor, what other recommendations has the Inspector General developed to meet the fraud problem?

Answer: In 1979, the Inspector General recommended and the Administration sent a legislative proposal to Congress for a Civil Money Penalties Bill. This pending bill would permit more effective civil sanctions against health care program defrauders. With this legislation, prosecutors could recover taxpayer's funds in those instances where they did not wish to pursue criminal prosecution.

The Inspector General also supports the additon of a specific provision of the Social Security Act, making it illegal to counterfeit, alter, buy or sell social security numbers and cards. We further support the recommendation that the maximum monetary penalty for social security fraud be increased from $1,000 to $5,000.

Among the general Departmental areas where we have recommended changes to eliminate fraud and abuse problems are:

- Procurement -- The process of awarding grants and contracts needed tightening up.
- Grantee and Contractor Performance -- The Department needed to improve its monitoring and technical assistance of grantees and contractors.
- Computer Security -- The Department needed to devote additional attention and resources to improvement of the security of computer systems.

Question: What recommendations are you making to facilitate identification and prosecution of Medicare and Medicaid fraud?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

POTENTIAL MEDICAID SAVINGS

Question: What have been the total savings achieved to date as a result of the efforts of State Fraud Control Units?

Answer: The States have reported $39,048,178 in savings to date, in terms of overpayments identified or collected, restitution ordered, and fines or other penalties. This does not include any cost savings which we have conservatively estimated to occur from fraudulent billings that could have been expected to have continued had not the provider been convicted and excluded from the program. Nor does it attempt to measure savings from the deterrent effect gained from criminal prosecutions.

We have not calculated the full savings from exclusions, or from the deterrent effect of unit criminal activities, but we are of the opinion that these benefits exceed the costs of the units. The General Accounting Office, in a report dated October 6, 1980 found that the combined effects of the units' benefits could outweigh the units' costs and recommended that Congress pass permanent incentive funding for the units.

Question: What are the projected savings?

Answer: We estimate that the direct overpayments, recovered, restitutions, and fines attributable to the units for FY 1981 will be $21,045,000. Overall, we should point out that the first quarter of FY 1981 indicates a strong increase in the units' criminal accomplishments, which we view as a better measure of unit effectiveness than their civil recovery activity.

Question: What are the Federal and State costs for operating fraud control units?

Answer: Federal and state expenditures for the units in FY 1980 were $29,332,810, including $26,399,529 Federal and $2,933,281 state.

BLOCK GRANT PROGRAMS

Question: If block grants become a reality, consolidating some 40 HHS programs, will there be any shift in civil rights enforcement from the Federal Office of Civil Rights to the State OCRs?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

STATE AGENCY INVESTIGATIONS

Question: Currently, when a discrimination complaint is registered against a program that receives matching State and Federal funds, do both Federal and State OCRs investigate? If not, what is the method for deciding who investigates the complaint?

Answer: If a State civil rights agency with competent jurisdiction is investigating a complaint that was also filed with OCR, we would confer with the State officials and the complainant to determine which agency should proceed. In addition, under Title VI of the Civil Rights Act, State agencies that carry out continuing programs of Federal financial assistance are required to adopt methods of administration to assure that subrecipients are complying with Title VI. Under the methods of administration State program agencies have investigated Title VI complaints. Title VI prohibits discrimination on the basis of race, color, or national origin in federally assisted programs.

EFFECT OF PROGRAM CONSOLIDATION

Question: With consolidation of numerous activities into one or a few programs, would you anticipate a reduced number of complaints to be filed, and would the number of compliance reviews undertaken be reduced?

Answer: At this time we cannot predict whether the number of complaints or compliance reviews would decline. Once the Administration's policy has been established, we will provide the Subcommittee with an estimate.

COMPLAINT INVESTIGATIONS

Question: You state that in fiscal 1980, OCR received 1,776 complaints alleging civil rights violations. In fiscal 1981, you estimate you will have 2,256 complaints, and a 50 percent increase in fiscal 1982. In fiscal 1980, how many instances of noncompliance with civil rights laws and regulations were uncovered as a result of investigating these complaints?

Answer: In fiscal year 1981, we estimate that the number of complaints received will rise to about 1,900 receipts. This is a projection based on historic trends and the number of complaints received during the first quarter of fiscal 1981. We do not anticipate a 50 percent increase in receipts in fiscal year 1982. Of the 472 complaint cases investigated in fiscal year 1980, 155 cases resulted in corrective change.

Question: What was the distribution of these complaints among the handicapped, minorities, women, and the aged?

Answer: Of the complaints received in fiscal year 1980, 304 complaints were filed by minorities; 31 complaints were filed under Title IX of the Education Amendments of 1972, prohibiting sex discrimination; 934 complaints were filed by handicapped persons; 12 complaints were filed under the Age Discrimination Act; and 495 complaints alleged multiple violations of these statutes or violations of other civil rights-related requirements.

Question: What was the distribution of complaints between discrimination in employment and discrimination in service delivery?

Answer: About 40 percent of the complaints received involve employment discrimination issues.

Question: What recommendations for either new regulations or laws did OCR make to the Department last year as a result of complaint investigations? Were any of the recommendations implemented?

Answer: As a result of complaint allegations and other factors, OCR recommended that the Department propose a regulation to clarify the steps recipients must take to ensure that persons of limited English proficiency have equal access to program services. A notice of the decision to develop such a regulation under Title VI of the Civil Rights Act of 1964 was published in the Federal Register of December 17, 1980. To date a proposed regulation for public comment has not been issued. No laws or other regulations were recommended as a result of complaint cases. However, on an ongoing basis OCR develops compliance standards applying the regulatory provisions to particular programs or practices.

Question: What is the turnover time from the time a complaint is registered to the time a complaint is investigated? Are all complaints investigated?

Answer: On the average it takes approximately 265 days for OCR to close out a complaint which is investigated and which leads to remedial action through negotiations. However, in about 50 percent of these cases only 149 days evolve from the time of receipt to closure. The average time period is high because the investigative time expended in many cases can be substantial due to the nature of the allegations, the complexity of the issues, and the size and number of recipient programs involved. Investigative time usually includes an on-site investigation, the collection and analysis of compliance information, issuance of a letter of findings, and negotiations leading to a voluntary settlement in cases where violations are found to exist. Most complaints do not require an investigation. Of those complaints resolved and closed out administratively without an extensive investigation, an average time period of 85 days is expended.

Question: Were any Federal grants or contracts terminated in fiscal 1980 as a result of discrimination complaints investigated by the OCR?

Answer: No funds were terminated during fiscal year 1980.

COMPLIANCE REVIEWS

Question: There are approximately 825,000 recipients of Department of Health and Human Services funds. How does the Office for Civil Rights collect data on the race, ethnic background, age and sex of beneficiaries for programs funded by the Department?

Answer: The number of recipients referred to includes approximately 86,000 contractors subject to Department regulations. In the past four years OCR has conducted two surveys that provide compliance information on the extent to which minorities and handicapped persons are participating on an equal basis in Department-funded programs. Survey data indicate whether compliance problems exist and where OCR should allocate its investigative resources. In addition, some beneficiary data are collected by the Department's program agencies.

Question: Does OCR collect equal employment opportunity statistics on grantee workforces?

Answer: The surveys OCR has recently conducted have not included questions relating to equal employment opportunity. However, in conducting a complaint investigation OCR would ask the recipient to provide employment data if such data were relevant to the complaint and essential to make a compliance determination.

Question: How does OCR choose where to perform compliance reviews?

Answer: OCR relies on survey data, the source and nature of discrimination complaints, and other information such as research reports to determine the programs and program recipients that should be reviewed.

Question: What is considered sufficient reason to trigger a compliance review?

Answer: There are a variety of factors that could "trigger" a compliance review. Survey data usually identify program recipients that may not be complying with statutory or regulatory civil rights requirements. OCR may receive a series of complaints or reports indicating that a particular policy or practice adopted by program recipients violates the law. Reports issued by other Federal agencies or by non-governmental groups frequently identify compliance problems that the Department should focus on. Finally, in a number of cases OCR has conducted reviews as a result of court litigation.

TITLE VI COMPLIANCE

Question: In August 1980, GAO submitted a report to Congress recommending that the Department of Health and Human Services step up efforts to review the Title VI compliance status of federally assisted programs. What is the status of OCR's Title VI compliance reviews?

Answer: In fiscal year 1980 OCR completed 174 compliance reviews. A total of 219 compliance reviews were carried over into fiscal year 1981.

Question: What steps has OCR taken to ensure that all federally assisted medical facilities are desegregated?

Answer: As a condition of receiving Department funds recipients must submit an assurance of compliance with Title VI of the Civil Rights Act. If OCR receives information indicating that a facility is illegally segregated by race, or denies admission on the basis of race, OCR would conduct an investigation. In addition, during a compliance review OCR would address any alleged practice of segregation that came to our attention. Finally, surveys are designed, in part, to determine whether discrimination may exist in admission, referral, or placement practices.

FOSTER CARE PROGRAMS

Question: How is OCR dealing with discrimination in Federal foster care programs?

Answer: First, if a complaint is received alleging discrimination in placing children in foster care programs, OCR would conduct an investigation. Secondly, in fiscal year 1980 OCR conducted a survey to determine whether compliance problems exist in the out-of-home placement of children by local public welfare and social service agencies. The survey data will be used in conducting reviews. Finally, OCR has worked with the Children's Bureau of the Department's Administration on Children, Youth and Families to incorporate civil rights standards in program agency reviews.

ADVISORY BOARDS

Question: What is OCR doing to assure representation of minorities and the handicapped on advisory boards of programs and activities receiving Federal assistance?

Answer: Section 80.3(b)(1) of the regulation implementing Title VI of the Civil Rights Act provides that no program recipient may on grounds of race, color, or national origin deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program. Similarly, recipients may not discriminate against handicapped persons in filling positions on planning or advisory bodies. OCR would investigate if a complaint were received alleging discrimination in appointing members of planning or advisory committees.

FINDINGS OF NONCOMPLIANCE

Question: In fiscal 1980, how many instances of noncompliance with civil rights laws and regulations were uncovered as a result of compliance reviews?

Answer: In fiscal year 1980, 123 of the compliance reviews conducted resulted in findings of noncompliance.

Question: What percentage of these noncompliance findings resulted from access to program services, and what percent resulted from employment inequities?

Answer: Of the 123 compliance reviews that resulted in findings of noncompliance, 112 cases involved access to program services. Employment discrimination was found in two of the reviews. Finally, in nine of the cases, noncompliance was found because of employment discrimination as well as the failure to provide access to services. It should be stressed that most reviews do not address employment issues.

Question: When noncompliance is discovered, what steps does OCR take to deal with this situation?

Answer: Under the nondiscrimination statutes and implementing regulations, OCR is obligated to provide a recipient with an opportunity to comply with the civil rights requirements on a voluntary basis when violations are found to exist. Hence, in cases of noncompliance OCR attempts to negotiate a voluntary settlement. Technical assistance is also made available to develop an appropriate remedy. However, if voluntary compliance cannot be achieved and the recipient declines to take the necessary remedial action, OCR initiates administrative enforcement proceedings or refers the case to the Department of Justice for court action.

TECHNICAL ASSISTANCE MATERIALS

Question: What is the extent of corrective changes that have taken place as a result of OCR issuing handbooks and other materials containing information about how to comply with civil rights laws?

Answer: OCR has not conducted a systematic, comprehensive evaluation of the extent of corrective changes generated by technical assistance materials. However, several indicators suggest that the material has played a key role in alerting recipients to compliance standards and in encouraging voluntary compliance. For example, over 50 percent of the recipients who received a guidebook on self-evaluation reported that they used the suggested procedures in conducting their self-evaluations. The demand for OCR publications from health care and social service providers is high. On a case-by-case basis, many recipients report that the difficulties encountered in complying with civil rights standards are being resolved by means of technical assistance.

Question: What materials for distribution is OCR concentrating on in fiscal 1982?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

Question: How many materials were disseminated by OCR during fiscal 1980, and at what expense to the Department?

Answer: In fiscal 1980 OCR distributed approximately 180,000 documents from headquarters to recipients, beneficiaries, Regional Technical Assistance Staff offices, elected officials and other Federal agencies. Additionally, approximately 34,000 documents were on order and 16,000 documents in stock at the end of the fiscal year for a total of 230,000 documents. The cost of these documents was approximately $110,000.

Question: The Office of Civil Rights has requested 58 positions to carry out compliance training. OCR also requested an additional $3,000,000 for technical assistance contracts to assist in compliance training. In training fund recipients how to comply with civil rights regulations, wouldn't it be more cost-effective to produce a greater number of training videos than to send employees and contractors out into the field?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

HANDICAPPED PERSONS--THE BLIND

Question: A Department of Labor administrative review was concluded in May 1980 with the finding that the Department of Labor lacks sufficient authority to establish a minimum wage requirement on behalf of blind workers. A Fair Labor Standards Act exemption, which applies to blind workers, allows pay rates to be as low as 25 percent of the Federal minimum wage. To what extent does the Department of Health and Human Services award grants and contracts to individuals and programs that have applied for and received this exemption?

Answer: HHS grant and contract award procedures do not include asking for this type of information in applying for or awarding of funds. We cannot tell the extent to which funds are awarded to individuals and programs that have applied for and received the exemption.

Question: To what extent has the OCR received inquiries on this issue during the last year?

Answer: OCR has not received any inquiries in this area.

Question: Has the Department formulated a policy or offered a recommendation for legislation to the Congress to remedy this situation?

Answer: The Department would not normally be involved in this policy area which is under the jurisdiction of the Department of Labor.

SURVEY OF INCOME AND PROGRAM PARTICIPATION (SIPP)

Question: The Survey of Income and Program Participation--called SIPP--is being devised to collect detailed statistics on government transfer and benefit programs for the purpose of enhancing department-wide planning and program effectiveness. When will SIPP be available for use?

Answer: Data from the SIPP are expected to be available by December of 1982.

Question: What will the survey be used for?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the subcommittee.

Question: SIPP is purported to be an example of cross-agency research which many units of the Department will be able to use. Has policy research developed any other projects of this nature?

Answer: ASPE has developed a number of projects, the results of which will be useful to other agencies or to units within the department.

The Monthly Reporting (DHHS and USDA) project is looking at the impact of an automated monthly retrospective reporting system on benefit outlays and administrative costs and functions of the AFDC and Food Stamps programs. This project constitutes the first attempt to develop and study a joint AFDC-Food Stamps reporting system.

The Performance Measurement Study (Social Security Administration and USDA) is looking at local welfare office administration in terms of accuracy and client service and administrative costs in both the AFDC and Food Stamp programs.

The Quality Control Study (AFDC and Medicaid Programs) is looking at techniques for reducing payment error by states.

The State and Local Fiscal Contracting Study is looking at the fiscal retrenchment of states in response to Proposition 13-type legislation resulting in reductions in a whole range of services across agencies.

A Poverty Research Center (DHHS and DOL) is being set up to look at causes of poverty and government policies to reduce it.

We believe these kinds of projects are eminently valuable because they bring a multi-program perspective to the analysis of issues which cut across program areas.

AID FOR DEPENDENT CHILDREN (AFDC)

Question: Experiments with the so-called "look-back" approach to funding the Aid to Families with Dependent Children (AFDC) program led to inclusion of this approach in the Carter Administration's welfare reform proposal. It is called "Monthly Retrospective Reporting." How much HHS research money has been spent to study this method?

Answer: In the initial test of monthly retrospective reporting among AFDC clients in two Colorado counties, approximately $4 million was spent designing, developing and operating the test system during three years, and about $1.5 million was spent on data collection and analysis. In the expanded round of projects in Michigan, Massachusetts and Illinois we have invested $12 million in the combined activities of designing and developing various models of monthly reporting systems in a total of 14 large urban welfare offices, and designing analytic methodologies and data collection strategies to answer a variety of research questions.

Question: How much has been used to explore other possible administrative improvements?

Answer: The process of studying Monthly Reporting involves comparing it to other administrative techniques. For example, our research will compare Monthly Reporting to existing redetermination procedures in terms of cost effectiveness.

Approximately $1 million has been spent over the past two and half years on a general analysis of administrative techniques, including the development of computer models to facilitate comparisons among individual administrative methods. This project is jointly supported by the Food and Nutrition Service of the Department of Agriculture, this office and the Office of Research and Statistics in the Social Security Administration. This study will perform analysis designed to identify more efficient techniques for understanding and integrating the administration of the Food Stamps and AFDC programs.

Internal staff are performing a cross-sectional analysis of quality control data from the AFDC program to identify factors and administrative practices that correlate with low error rates.

The monthly reporting research has led us to research other relevant policy questions about administration of the welfare program. We are in the process of developing research into short-term administrative reforms and improvements. Areas of interest are likely to include the relative cost benefit of home visits, of selective case actions, alternative verification techniques, and other Quality Control corrective actions. Major objectives would be to build state capacity for analyzing alternative adminiistrative reforms, and to disseminate valuable administrative technology among states.

Question: What gains have resulted from this research?

Answer: In Colorado, we found a net savings in grant payments to clients of 4.3% in the first year. This could mean an annual dollar savings to just those two counties of $1 million. We also found that on average, over 90% of clients can and do file their monthly reports correctly and on-time. However, we cannot confidently predict the various sources of these savings that accrued in Colorado. For example, it appears that some portion of the savings comes from terminating otherwise eligible clients from the rolls because they failed to file a report form. We expect to acquire more definitive answers to these and other issues in the new round of urban projects. In the meantime, we have learned a great deal about the costly, complex and time-consuming tasks of implementing a monthly reporting system in any state.

- o We have identified the many steps required to set up and implement a Monthly Reporting system. Nearly all AFDC policies and administrative procedures are affected -- from intake to case maintenance to client notices to retroactive check adjustments.

- o We know the scope required of computer systems in order to support a Monthly Reporting system.

- o We have rough estimates of the time and cost required to implement these policies.

The breadth of practical experience we will have ultimately gathered from five states would be invaluable to the Department if it is to assist states in implementing such a system.

Finally, the Colorado experience has enabled our office to refine analytic methodologies which promise significant policy formulation payoff in the areas of AFDC administrative costs, administrative organization and Quality Control measurement and corrective actions.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PAYMENT ERROR RATE

Question: In March of 1979, the Department said it was going to do a study to determine a "reasonable" error rate for payments under the Aid to Families with Dependent Children program. When will the Department complete this study?

Answer: The Department's study of Quality Control error rates in AFDC will be completed in the Fall of 1981. A statistical analysis of QC error rates as reported in the April-September 1978 review period will be included in the final report. Information on local agency administrative methods as well as socioeconomic and demographic characteristics have been included in this analysis.

In addition to the statistical analysis, case-study investigations were conducted in eight States -- California, Georgia, Illinois, Massachusetts, Michigan, Texas, Washington, and Wisconsin. A comparative analysis synthesizing the findings has been written. All eight cases and the comparative analysis will be published when the error rate study is completed this fall.

Question: The Michel Amendment imposes fiscal sanctions for states which fail to bring their AFDC error rates down to 4 percent. If your study finds that going down to a 4 percent error rate is an unreasonable goal for some states, will the Department recommend that a higher error rate be adopted?

Answer: This is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the subcommittee.

POLICY RESEARCH

Question: It is charged that Policy Research has failed to coordinate its activities with those of other HHS offices to come up with an overall research and evaluation strategy for welfare.

What process exists for making sure that research projects undertaken by, or funded by, the Office of the Secretary do not duplicate projects underway in other HHS agencies, such as the Office of Research and Statistics (ORS) in the Social Security Administration?

Answer: The Assistant Secretary for Planning and Evaluation (ASPE) coordinates for the Secretary procedures for overseeing the Department's social research. In particular, ASPE prepares the Secretarial guidance on research priorities. This guidance requires each agency to develop and circulate a plan each year governing strategy for all research and evaluation. These plans, including project descriptions, are circulated for review by other agencies. Thus, for example, ASPE comments on ORS proposals, and vice versa. ASPE also requires that each project be reviewed in depth by agency staff experts in the subject area prior to start up.

In areas such as welfare, where there is substantial potential for overlap ASPE and ORS collaborate in depth on numerous individual projects, such as the monthly reporting demonstrations and the SIPP. These and other projects often involve the collaboration of HCFA (Medicaid), USDA (Food Stamps) and other agencies as well. Each agency's decision to start a project is governed not only by the the other agency's views on the project, but also by the overall research agenda of the Department in the welfare area. These coordination activities reduce the potential for any unnecessarily duplicative research projects in the welfare area.

[CLERK'S NOTE.—The following is the administration's response to those questions in the record that were under review by the Secretary at the time the Department submitted earlier responses.]

Question: The programs proposed for block grants are purported to overlap and duplicate other programs in services provided and/or populations served. Do you agree? Can you provide us with some examples?

Answer: I agree with the thought, but it requires some explanation. The problem is not that the same people are getting the same services from more than one agency, but rather that under the present system of funding, it is very difficult for a State or community to coordinate related services that an individual may be receiving and to provide common support services in an efficient manner. These difficulties are a necessary result of the separation of funding programs at the Federal level.

Different Federal programs, with different rules, funding diverse agencies provide similar services in a manner that makes the coordination of programs very time-consuming and frequently impossible. Certain populations and individuals receive varying benefits from a variety of programs. We see that in programs that serve children in need of substitute care. Title XX, Child Welfare Services and AFDC Foster Care programs can be used to provide this care. The parents themselves may be in need of counseling or other social and health services provided by other programs. It is difficult to ensure coordinaion of these services. Another area in which coordination is important but difficult to achieve is in providing health, mental health and general social services to low-income families. Many of the programs in health services and social services block fund related services to the same person or populations.

Question: To what extent would block grants make services provided more accessible to individuals in need?

Answer: There are three basic ways in which accessibility will be improved. First, resources can be focused on those individuals most in need. The whole point of the block grants is to allow State governments--not the Federal government--to determine which individuals are in need. States will be able to rectify the problem of having inadquate funds to spend on a high service priority while being encouraged to spend on services of much less importance.

Secondly, States and communities will be in a much better position to coordinate supporting services that are intended to improve access. Transportation services, information and referral services and counseling services are provided under many of the Federal programs and yet because they are administered separately at the Federal level, there are substantial barriers to providing and managing them in a consistent,coordinated and efficient manner.

Finally, block grants contain only essential requirements and limitations on how States provide services. This will result in elimination of innumerable Federal rules that constrain innovative delivery systems as well as support and access services that are adapted to community needs and conditions.

Question: What controls would be in block grants to protect against civil rights and financial abuses?

Answer: The block grant bills do not in any way displace general provisions of the law, such as Title VI of the Civil Rights Act of 1964, that forbid discrimination in the award of Federal financial assistance. With respect to financial abuses, the block grant bills require State audits, authorize the Secretary to audit the State accounts, and retain general provisions of law, such as Section 202 of the Intergovernmental Cooperation Act of 1968--which assures that grant funds will be drawn down by the States only as needed--that serve to protect the fiscal concerns of the Federal government.

TECHNICAL ASSISTANCE MATERIALS

Question: What materials for distribution is OCR concentrating on in fiscal 1982?

Answer: OCR will continue to distribute a variety of materials to recipients, beneficiaries, and local and State agencies.

These materials set forth compliance standards under the civil rights laws that OCR enforces.

Question: The Office of Civil Rights has requested 58 positions to carry out compliance training. OCR also requested an additional $3,000,000 for technical assistance contracts to assist in compliance training. In training fund recipients how to comply with civil rights regulations, wouldn't it be more cost-effective to produce a greater number of training videos than to send employees and contractors out into the field?

Answer: It is important that technical assistance aimed at securing voluntary compliance with the civil rights laws be properly responsive to the needs of recipients of federal financial assistance. The provision of cost-effective and useful technical assistance usually requires direct contact with recipients in order to inform them adequately on the requirements of the civil rights laws, and assist them in meeting their civil rights responsibilities. While OCR is involved in producing videotapes on selected civil rights issues of broad applicability, a significant portion of the OCR resources are focused on providing, through staff and contracts, technical assistance which is tailored to the specific problems and concerns of individual recipients. For example, regional technical assistance staff may conduct, on request, an on-site review of a hospital's physical plant in order to advise the institution on what cost-effective alterations or modifications might be made in order to be in compliance with the program accessibility requirements under Section 504. It is only through this direct contact that technical assistance can be an effective tool in bringing about voluntary compliance with civil rights laws.

BLOCK GRANT PROGRAMS

Question: If block grants become a reality, consolidating some 40 HHS programs, will there be any shift in civil rights enforcement from the Federal Office of Civil Rights to the State OCRs?

Answer: Because the block grants constitute Federal financial assistance the Department will continue to enforce the Federal nondiscrimination requirements. At the same time, we anticipate a cooperative State role in assuring compliance. The block grant legislation which the Department is proposing will contain nondiscrimination provisions that recognize the Federal and State roles in this area.

EFFECT OF PROGRAM CONSOLIDATION

Question: With consolidation of numerous activities into one or a few programs, would you anticipate a reduced number of complaints to be filed, and would the number of compliance reviews undertaken be reduced?

Answer: At this time it is not possible to estimate whether program consolidation will necessarily reduce the number of complaints filed or the number of compliance reviews. OCR does anticipate a decrease in compliance reviews due to staff reductions proposed in the revised fiscal year 1982 budget request.

SUBCOMMITTEE RECESS

Senator SPECTER. The subcommittee will now recess until Friday, February 27, and we will meet in this room at 10:30 a.m., to hear testimony on appropriation requests for both the Office of Human Development Services, and the Department of Education salaries and expenses.

Thank you all very much.

[Whereupon, at 4 p.m., Wednesday, February 25, the subcommittee was recessed, to reconvene at 10:30 a.m., Friday, February 27.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

FRIDAY, FEBRUARY 27, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:30 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Daniel K. Inouye presiding.

Present: Senator Inouye.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HUMAN DEVELOPMENT SERVICES

STATEMENT OF WARREN MASTER, ACTING ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

ACCOMPANIED BY:
- BARBARA SABOL, DIRECTOR, OFFICE OF PROGRAM COORDINATION AND REVIEW
- JOHN BUSA, ACTING COMMISSIONER, ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES
- FRANCIS LYNCH, ACTING COMMISSIONER, ADMINISTRATION FOR DEVELOPMENTAL DISABILITIES
- M. GENE HANDELSMAN, ACTING COMMISSIONER, ADMINISTRATION ON AGING
- A. DAVID LESTER, COMMISSIONER, ADMINISTRATION FOR NATIVE AMERICANS
- JOSEPH A. MOTTOLA, DIRECTOR, OFFICE OF MANAGEMENT SERVICES
- ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT DIRECTOR, BUDGET

SUBCOMMITTEE PROCEDURE

Senator INOUYE. The subcommittee will please come to order.

This morning we will begin with testimony concerning the Office of Human Development Services. Then we will move to the Department of Education, receiving testimony on salaries and expenses and civil rights appropriations.

The first witness this morning is Mr. Warren Master, the Acting Assistant Secretary for Human Development Services.

PREPARED STATEMENTS

I have been advised that the staff has conferred with you on the opening statements. We have received those statements and without objection they will be made part of the record in full.

[The statement follows:]

STATEMENT OF WARREN MASTER

I am pleased to appear before you today to discuss the programs supported under the Grants to States for Social Services appropriation. A level of $2,991,100,000 is available for these programs under the Second Continuing Resolution for fiscal year 1981.

The Grants to States for Social Services programs represent the core of support for all Human Development Services and is focused on strengthening family and community support systems, on improving management systems, and on improving the quality and delivery of services.

Under the continuing resolution $2,700,000,000 is available for grants to States under Title XX; $200,000,000 is available for grants to States for day care; $16,100,000 is available for social services grants to the territories, and $75,000,000 is available for State and local training.

These programs are designed to meet the goals of establishing economic self-support; establishing self-sufficiency; protecting children and adults from abuse, neglect, and exploitation; helping families stay together; preventing or reducing inappropriate institutional care, and arranging institutional placement when appropriate.

Regulatory Activities

These programs operate under regulations which closely conform to the requirements of the authorizing statutes. Only in a few instances do regulations add requirements not explicitly specified in the statutes. In this sense, the Office of Human Development Services is not a "regulatory agency" but uses regulations to operationalize legal requirements and to administer programs. Some regulatory provisions involve both costs and cost savings. These include disclosure requirements to prevent fraud and abuse; monitoring requirements to assure that only eligible persons receive services; and fiscal requirements which assure accountability from public and private services providers.

We estimate that in 1981 four person years at a cost of $112,000 are required to develop and promulgate regulations, and ten person years and $280,000 are required to enforce regulations. With respect to costs to the States and private sector, we are unable to separate out a viable estimate of "regulatory costs" as opposed to costs of providing services and administering the program.

Thank you, Mr. Chairman. My colleagues and I will be happy to answer any question you and the committee may have.

I am pleased to appear before you today to discuss the programs administered by the Office of Human Development Services. In 1981, the second continuing resolution provided $2,194,083,000 to support programs which serve special segments of the population including children, youth and their families; older Americans; those who are developmentally disabled; and Native Americans.

The Administration for Children, Youth and Families, supported by a level of $1,345,078,000 in 1981, administers eight programs: Head Start, Child Welfare Research and Demonstration, Child Abuse and Neglect, Runaway and Homeless youth, Child Welfare Training, Child

Welfare Services State grants, Adoption Opportunities, and the Aid to Families with Dependent Children Foster Care program. These programs are designed to improve the quality of child day care; to design and implement programs to improve the services delivery systems and to improve the quality of life for children, youth and their families; and to promote the welfare of children by providing services that supplement and/or substitute for parental care and supervision. Emphasis is on meeting the developmental needs of pre-school children from low-income families; on developing better services for vulnerable children and youth, particularly children in need of child day care, foster care, or adoption; on providing better services to runaway and homeless youth; and on improving services to children and youth who are abused or neglected.

The Administration on Aging, supported by a level of $683,756,000 in 1981, implements programs which foster independence of the socially and economically needy elderly and which provide alternatives to institutionalization. Emphasis is on maintaining meal levels provided in the past. Resources are focused on the most vulnerable elderly: the chronically impaired, those over 75, those who are alone, and minorities. Over 88 percent of the funds available are distributed by formula to States to provide social services and meals to the elderly. The nutrition program provides 431,400 meals per day, five days per week.

The Administration for Developmental Disabilities, supported by a level of $61,181,000 in 1981, provides assistance to States to assure that developmentally disabled persons receive care, treatment, and other services to enable them to achieve their maximum potential and to assure protection of their legal and human rights.

Social Services research, supported by a level of $3,750,000 in 1981, conducts research and evaluation targeted to the cross-cutting goals of the Office of Human Development Services.

The Administration for Native Americans, supported by a level of $33,800,000 in 1981, serves American Indians and Alaskan and Hawiian natives in order to promote the goal of social and economic self-sufficiency. Emphasis is on assisting Native American groups establish and maintain structures and mechanisms necessary for planning and the coordination of Federal and non-Federal resources.

A level of $63,518,000 is available for salaries and expenses. These funds support the Federal administration of all programs administered by the Office of Human Development Services.

A level of $365,000,000 is available in 1981 for the Work Incentive Program. Funds for this program are appropriated to the Office of Human Development Services. Authorizing legislation dictates that this program be dually administered by the Department of Labor and the Department of Health and Human Services. This year the Senate included hearings for the Work Incentive Program with Department of Labor employment and training programs on February 3.

Regulatory Activities

The programs administered by the Office of Human Development Services operate under regulations which closely conform to the requirements of the authorizing statutes. Only in a few instances do the regulations add requirements not explicitly specified in statutes. In this sense, the Office of Human Development Services is not a "regulatory agency" but uses regulations to operationalize legislation and to administer programs. Regulations include disclosure requirements to prevent fraud and abuse; monitoring requirements to assure that only eligible persons receive services; and fiscal requirements which assure accountability from public and private service providers. In fiscal year 1981, it is estimated that 12.1 person years of effort costing $338,700 will be needed to develop and promulgate regulations, while 138.1 person years of effort costing $3,870,000 will be required to implement and enforce regulations. While there may well be costs to States and to the private sector, it is not possible at this time to provide a viable estimate for these costs.

Thank you, Mr. Chairman. My colleagues and I will be happy to answer any questions you and the Committee may have.

Biographical Sketch

NAME : Warren Master

POSITION : Acting Assistant Secretary, Office of Human Development Services

BIRTHPLACE AND DATE : Bronx, N.Y. - May 2, 1942

EDUCATION : B.A. - City College of New York, 1965
M.A. - Indiana University, 1970

EXPERIENCE

Present : Acting Assistant Secretary, Office of Human Development Services.

1980-1981 : Director, Office of Policy Development, HDS.

1977-1980 : Director, Office of Policy and Management Control, HDS.

1976-1977 : Special Assistant to the Assistant Secretary for Human Development Services.

1973-1976 : Senior Management Analyst, Office of the Assistant Secretary for Administration and Management.

1972-1973 : Program Analyst, Office of the Comptroller, Office of Economic Opportunity.

1970-1972 : Community Action Field Representative, Office of Economic Opportunity Region III.

1967-1969 : Teaching Associate, Indiana University.

1965-1967 : Peace Corps Volunteer in Turkey.

1961-1965 : Supervisor for Guest Relations, CBS-TV, New York, N.Y.

AGENCY OVERVIEW

Senator INOUYE. If you would like to summarize your statement we can get on with the questions.

Before proceeding, would you care to introduce your staff.

Mr. MASTER. If it is all right with you, in a couple or 3 minutes I would like to give a very brief, broad overview of what the agency is.

In a nutshell, it is the social services arm of the Department. It was created as the Office of Human Development in the spring of 1973. At that time it was sort of a holding company within the Office of the Secretary for a number of programs targeted to vulnerable populations.

The two biggest programs were the Head Start program, which in 1973 was funded at roughly $400 million a year, and the aging program, funded at approximately $200 million.

In 1975 the vocational rehabilitation program and the developmental disabilities program were added. And in 1977, there was a major change in the Department of Health, Education, and Welfare when OHD became the social services arm of the Department. That is when the title XX program, the grants to States for social services, was added to the agency, bringing it to its apogee in terms of funding, just under $6 billion a year, and with a staff across the country of roughly 2,000 people.

Last year, as you know, the vocational rehabilitation program was transferred to the new Department of Education.

In any event, today we have an agency of just under $5.5 billion. It is the social services arm of the Department. We have roughly 1,500 employees.

Briefly, to summarize the programs, the title XX program, which is a formula grant program of a general nature on social services through the States, is just under $3 billion a year in the fiscal year 1981 continuing resolution. It provides a broad array of services, touching all the different categorical population groups.

We also have four principal operating components of the agency that focus on particular categorical concerns.

The Administration for Children, Youth, and Families administers a series of children and youth programs, principally the Head Start program, funded at $820 million in fiscal year 1981, which is more than double what I mentioned earlier in 1973.

It also includes the child welfare services program which this year moves dramatically to $163 million. Foster care, the AFDC foster care activity, is at $305 million. Adoption assistance and other children, youth, and family programs such as the child abuse and neglect prevention, runaway youth, et cetera, are also included in the administration.

The Administration on Aging has a budget of over $600 million, and it works again through formula grants through State agencies on aging and substate agencies, area agencies providing nutrition services, home delivered meals, et cetera, and social services.

The other programs in the agency include the Administration for Developmental Disabilities. The bulk of the roughly $61 million in that program again goes to States in the form of a formula grant to not only provide services but to enhance planning and coordination of services for developmentally disabled in each of the States.

The remainder of the funds are used for discretionary programs.

The next program, administration for native Americans is a program that has roughly four components: One, the program for tribal communities in the continental United States; two, off-reservation Indian communities; three, programs for native Hawaiians; and four, Alaskan Natives. These are not formula grants. These are direct grants to communities.

We have a broad social services research authority that tracks pretty closely to the title XX activity, and that is funded at $3,750,000 in fiscal year 1981.

We have two White House conferences we are planning now, both for December of fiscal year 1981, the White House Conference on Aging and the White House Conference on Children and Youth.

We have a salaries and expense budget in fiscal year 1981 of roughly $65 million.

That in a nutshell is what the agency is about.

BLOCK GRANT PROPOSAL

Senator INOUYE. During the past several weeks we have heard much about the expansion of the title XX block grant approach and consolidating several of these categorical grants. There is much debate going on at this time. Do you support this?

Mr. MASTER. Do I support the concept?

Senator INOUYE. The concept; yes.

Mr. MASTER. Personally, as a career civil servant?

Senator INOUYE. Yes.

Mr. MASTER. Well, I haven't seen the details. The title XX program, for example, that we are talking about is in many respects a block grant. It is not particularly targeted. There is some targeting, but in general it is a formula grant that goes to the States, roughly $3 billion. States pretty much choose their own priorities.

Senator INOUYE. We have been told that the title XX block grant approach will be expanded to include, among other things, several programs administered by the Office of Human Development Services such as child welfare, child abuse, developmental disabilities, and the runaway youth program. After the consolidation, the total funding would be reduced to 80 percent of current levels. Do you support that proposal?

Mr. MASTER. I haven't seen that proposal made yet. I don't know that Secretary Schweiker, when he testified, went into any details of the block grant. But the proponents of the block grant, as I understand it, feel that the States are in a very good position to make those choices among the programs.

Again, I would have to wait to see what the details of that proposal are, not only the proposal but what Congress does as the Congress begins to consider these proposals.

Senator INOUYE. I believe the rationale for categorical grants is that States were not carrying out "their responsibilities" to their citizenry, and therefore, it was the responsibility of the Federal Government to take care of the needy, the disabled, the abused, and the poor. In this situation some States were doing well and others almost doing nothing in programs for these groups. How would that concept be changed by this block grant approach?

Mr. MASTER. Again, as I understand the arguments for a block grant approach, at this stage of the game most of those categorical programs were put into place before the States had a leg up on many of these issues. Over the years, I assume due largely to the categorical programs, States have begun to address those needs.

The proponents of the block grant program believe it is now time for the Federal Government to wean itself from that role. That is the general argument.

They point out, for example, that in the area of child welfare services that States put much more money into this area than the Federal Government, and in most of the other categorical—many of the other categorical areas—this has begun to take place.

TITLE XX TRAINING

Senator INOUYE. Do you believe that we have more than enough trained social workers?

Mr. MASTER. I am not very close to that particular issue. Perhaps I could have Barbara Sabol address that issue.

Ms. SABOL. The last figures that we have from the Bureau of Labor Statistics indicate that there is a shortfall in trained social workers from 1978, I believe, through 1982. However, in looking at social work training, particularly training as funded under title XX, we have to remember that the training program funds more than just social workers. As the Assistant Secretary has indicated, the States make decisions relative to title XX training in terms of who will be trained.

So, based on the particular State need and the particular problems they are addressing, they can train more than just social workers in the title XX training program.

But, yes, there does appear to be at this time a shortage of trained social workers.

Senator INOUYE. Then you would say that there is still a need to expend title XX dollars for training social workers?

Ms. SABOL. The States have indicated that there is a need to train additional social workers, particularly as they look at specific services, for example, child protective services, and adult protective services. In terms of the way the States are targeting their title XX training dollars, yes, they believe it is necessary to continue training social workers.

Senator INOUYE. How do you determine shortfall or need?

Ms. SABOL. I am not sure of the exact method. There have been studies in which questionnaires have been distributed to find out about turnover, how long people are staying in the profession, how the manpower pool relates to the number of people that a public welfare agency may need, or private and other public providers, what their need is. But for this particular statistic I am not sure how that was garnered.

Senator INOUYE. Is there some national mathematical standard, 1 for 1,000, something like that?

Ms. SABOL. If there is, Senator, I am not aware of what that is.

Mr. MASTER. There are a series of research demonstration projects that the Department has conducted over recent years that look at caseload data, and by pulling together, usually through some sort of a consortium mode, the people in the field, they come up with model standards or measures, the rules of thumb in the profession.

DAY CARE

Senator INOUYE. I realize at this stage it would be rather difficult to be discussing specific items in the budget, because we don't have the Reagan proposals before us. So we have to rely upon radio commentators or statements issued by good sources. We have heard that the support for day care centers will be eliminated. I don't know whether that is official or not. If such a proposal were carried out, how many heads of families would no longer be able to work?

Mr. MASTER. Let me speak first to the assumption. As I understand what I read in the newspapers, my sources, this is not likely to occur. But even in this block grant construct, again, just as in the title XX program, those decisions are left to the State in the block grant program unless that activity were excluded by law. I don't have any additional information.

Senator INOUYE. Do you feel sufficiently assured that under the block grant approach the States will carry on the day care center program?

Mr. MASTER. Yes; if I had to bet right now, I would bet that States will continue to carry on day care as a major activity. Again, it doesn't require that the States provide the day care service. And States spend from 20 to 25 percent of their title XX money for child day care. This is purely voluntary. That has been their pattern.

Senator INOUYE. If the day care center program was eliminated, how many heads of families would be affected?

Ms. SABOL. There are approximately 600,000 children per quarter who are receiving day care. If we make some assumptions about the number of children per family and base the estimate on the data for AFDC families of 2.6 people per family, and this figure has been constant over the last couple of years, I would estimate that approximately 400,000 heads of families would be affected.

Mr. MASTER. We can get back to you with a more specific answer.

Senator INOUYE. I suppose that most, if not all, of these working parents would be eligible for some other form of income security.

Ms. SABOL. Not necessarily, Senator. Under the title XX program day care services are provided to those who are AFDC recipients, but as well they can be provided to the income eligible category; that is, those people who are generally considered the working poor.

RESEARCH AND EVALUATION

Senator INOUYE. The evaluation of the impact of the programs, whether entitlement programs such as title XX or demonstration programs, provides the Congress with information upon which to make more sound decisions about the expansion, elimination, and restructuring of existing social service programs. Would you describe the activities of the Office of Human Development Services in the area of research and evaluation of the social service programs?

Mr. MASTER. Again, the research and evaluation activities are relatively decentralized in the agency. There is $3.7 million of activity, for research and evaluation of a general nature across the human services. Each of the program administrations, ACYF, administration on aging, native Americans, day care, run their own targeted research and evaluation activities.

That is a general answer. Would you like a brief description in each of the areas?

Senator INOUYE. If you could submit it for the record I would appreciate it.

[The information follows:]

ANA RESEARCH AND EVALUATION ACTIVITIES

The research, demonstration, and evaluation activities of the administration for native Americans are designed to obtain information not currently available on native Americans which is used for program planning and development. Demonstration projects are undertaken to stimulate innovations in service delivery, planning, and management by native Americans. Such activities are undertaken directly with Indian tribes and native American organizations or with their cooperation. The focus is on enhancing the capabilities of native Americans to influence their environment and to define, as well as achieve, their own economic and social goals. Cooperative efforts with other Federal agencies serve to marshal resources for problems which transcend the boundaries of organizational responsibilities.

The research, demonstration, and evaluation activities are part of a broad strategy of support for the objectives of the agency, and will include developing indicators for defining and assessing economic and social self-sufficiency and measuring the performance of the administration for native Americans program. Transferable technology that can make long-range improvements in the quality of life for native Americans will be identified, and successful planning and service delivery systems will be disseminated to additional tribes and groups.

ADMINISTRATION ON AGING

Senator INOUYE. I would like to now get to Administration on Aging. There is an increasing concern about the cost of long-term care in our Nation's nursing homes. In the Comprehensive Older Americans Act Amendment of 1978, the Administration was directed to develop policy alternatives to long-term care to insure the development of community alternatives.

Can you describe the Administration's activities in this area?

Mr. MASTER. Yes; let me refer to Gene Handelsman, the Acting Commissioner on Aging.

Let me preface by saying the Department does have major demonstration activities underway and is considering that demonstration at this time.

Gene?

Mr. HANDELSMAN. Mr. Chairman, we have several activities which are related to policy development and capacity building to improve services for functionally impaired older persons. One of the activities in this area is the national long-term care demonstrations. This program is part of a major departmental initiative aimed at testing the extent to which State and local government agencies can develop, coordinate, and manage long-term care services that: One, are available and accessible to those persons who need them; two, are provided in the least restrictive environment, preferably at home or, in other community settings; three, and can be delivered without any substantial amount of new dollars, by deemphasizing the use of acute care and nursing home facilities.

Models for managing, coordinating, and delivering long-term care services will be tested and evaluated. In fiscal year 1980 awards were made to 12 States. These demonstrations are being jointly funded with the Health Care Financing Administration which provides half of the funds.

Senator INOUYE. Do you see any good results coming out of these demonstration programs?

Mr. HANDELSMAN. It is too early to say, the first demonstrations were funded late in fiscal year 1980.

We also have financed some long-term care gerontology centers which will mobilize the resources of the universities to complement the community demonstrations at the service level.

Senator INOUYE. How long will it take before we can be assured of some alternatives to long-term care for older persons?

Mr. HANDELSMAN. The first two models of the national demonstration were initially funded in fiscal year 1980, for a 2-year period. In fiscal year 1981, we are planning to fund an additional two models. Findings from these demonstrations will have to be evaluated, so that it could be 5 years before recommendations are made.

IN-HOME SERVICES FOR THE ELDERLY

Senator INOUYE. There is concern about the high rising cost of nursing homes. Often families desire to care for aging parents at home. What has the Administration on Aging done in the area of supporting demonstration programs which provide services for the care of older persons in their own homes or in their children's homes?

Mr. HANDELSMAN. One of the priority services under title III of the Older Americans Act is to provide social services in individuals' homes. I must call to your attention that the proportion of noninstitutionalized elderly persons living alone has increased from 19 percent in 1960 to 30 percent in 1979; 41 percent of elderly women live alone. Thus, the increasing need for in-home services to enable those people to remain in the community as long as possible and to remain as independent as possible. In-home services provided by title III of the Older Amercians Act include home-delivered nutritional services, chore maintenance, and homemaker help.

Senator INOUYE. What about day care centers for the aging?

Mr. HANDELSMAN. There are some that are being funded by the Administration on Aging on a demonstration basis, and more and more area agencies on aging are beginning to fund this kind of activity which is an excellent supplement to the kinds of services that are required in homes.

It also enables families of older people to keep a person in their home longer and enables them to carry on with their normal activities.

Senator INOUYE. Have State agencies on aging been able to increase program efficiency and to improve coordination among the previously separate programs for the elderly?

Mr. HANDELSMAN. Increased coordination? Yes, sir: State and area agencies are coordinating available resources effectively. In terms of pooled funds to supplement the Older Americans Act program. The $661 million pooled in fiscal year 1980 resources amounted to more than the title III of the Older Americans Act appropriation. The resources pooled supplement the activities that are funded with title III allotments.

The Administration on Aging's regional offices are currently conducting an assessment of State and area agencies. As part of this assessment, coordination activities conducted by the agencies are being examined and technical assistance is provided, if required.

Senator INOUYE. Data from your agency for fiscal year 1979 show that only half of the people receiving social services under the Older Americans Act were classified as low income. Do you have any recent data indicating that a greater share of the low-income elderly persons are being served by the Older Americans Act?

Mr. HANDELSMAN. Although the Older Americans Act calls for services to all older persons, it does provide an emphasis on services to those older people who are socially or economically disadvantaged. We have several management initiatives which encourage the States to try to locate services in the geographical areas where these disadvantaged people live and to encourage the direction of those services to the socially or economically disadvantaged older person. We find that the proportion of low-income elderly receiving social services is increasing. In fiscal year 1979, they were 48 percent of the recipients of these services, in fiscal year 1980 low-income elderly represented 53 percent of the recipients of social services.

PROTECTIVE SERVICES FOR THE ELDERLY

Senator INOUYE. Last night I happened to turn on ABC Nightlife. They featured a commentary on abuse of the aged. Do you have any programs dealing with that?

Mr. HANDELSMAN. That is an area that we are focusing on in our research and demonstration activities. It is a phenomenon that has become more and more prevalent and until recently, has not been publicized. We have developed an initiative that will address this issue so that appropriate group services including protective services may be provided for these vulnerable older people. We also have programs financed under title XX.

Senator INOUYE. There is a report, I think, that San Francisco has a special program for security. Do you know whether that program is being financed by the Federal Government?

Mr. HANDELSMAN. I do not know. We can certainly report that for the record. The Administration on Aging has not provided funds for that particular project, but we do have an initiative on elderly abuse.

[The information follows:]

INITIATIVE ON ELDERLY ABUSE

The initiative deals with prevention, protection and treatment of elderly persons who have been mentally and physically mistreated, usually by their adult children or other relatives. Treatment for the abuser will also be encouraged.

The initiative deals with determining the extent of elderly abuse, the mechanisms for treatment and prevention and exploring ways in which traditional protective services can be enhanced and coordinated with other social services in order to provide services for all elderly who are at risk of being abused.

Projects will be involved in developing a data base on the prevalence of abuse among the elderly, investigating the factors which might be able to be used as predictors, identifying the ways in which the elderly and the current caregivers including providers are dealing with abused elderly and options for reducing abuse and improving the treatment modes available. The present need is to increase public awareness of the prevalence of the problem and the limited availability of services for the abused, and at the same time exploring ways to improve their quantity and quality of services. Options will be examined for providing respite and a full range of supportive services for caretakers including counseling of families to help them understand and deal with their frustrations and guilt feelings. In the area of prevention, there will be encouragement for the development of formal and informal associations of caregivers, which match families seeking respite care with persons willing to provide it at a mutually agreed upon fee. A hotline will be established in at least one community which will be a coordinated effort between various social services agencies.

Projects currently funded include: Massachusetts Elder Abuse Project, the purpose of this project will be: to increase knowledge about elderly abuse and neglect, particularly incidence, identification methodologies and intervention techniques. The project will test two models for program development; one in Boston and the other in Worcester, Massachusetts. The programs in each city will include health and mental health services, social and legal services, housing and services to abusers as well as abused and neglected elderly.

In Worcester, an intensive outreach and case-finding approach will be utilized to determine the incidence of abuse in a typical medium size city and its environments. A case management model supplemented with appropriate community support services will be employed to overcome the barriers to effective intervention in abuse cases.

The Boston site will plan and develop a coordinated elder abuse and neglect response system for the city, which will include an intensive public information campaign, supportive services, intervention protocols and service assessment procedures.

A training program for provider agencies and direct service workers will be developed and implemented for both sites. An evaluation of the activities and results of the entire project and the activities in each site will be conducted.

This project is expected to: 1) develop two models of coordinated, comprehensive services for prevention, detection and resolution of elderly abuse, 2) improve data on typology, incidence and causes of elder abuse and neglect, and the costs of providing services to abused elders, 3) determine the efficacy of these two models as a basis for a statewide elder abuse program, and 4) disseminate information and results locally and nationally.

The Demonstration Project on Elderly Abuse, this project is designed: to develop and demonstrate a viable strategy for the prevention and treatment of elderly abuse through a comprehensive and coordinated service system.

The network developed to comprehensively address the problem of elderly abuse will be built on the structure of the existing service delivery system. Legal, as well as service-related remedies will be explored, both for comprehensive system development and for individual cases of abuse. Education and consultation with the general community and with significant service providers will be tested as a preventive mechanism. Individual case intervention for abuse will emphasize coordinated "team" diagnosis and treatment, providing service to the elderly person and to caretaker(s) in need. A data system will be developed to support activities.

The project is to demonstrate a viable community approach for the effective and efficient response to the problem of elderly abuse. It is anticipated that such a model will be beneficial to other communities searching for strategies to address the problem.

The Elder Abuse Program, the purpose of this project is: to create awareness of the nature and extent of elderly abuse in Rhode Island and develop and implement a system of alternative methods for treatment and prevention of abuse.

The Media will be utilized to assist in increasing community sensitivity to the problem. Hot Line Service will be available for reporting incidence and providing information and referral on counsling and intervention services. Training on domestic violence will be provided to service providers and law enforcement personnel. Outreach services to all reported cases of abuse and neglect will be made available including emergency shelter where appropriate. Interagency coordination and community linkages will be used to increase resources. A survey instrument will be developed to measure type and incidence of elderly abuse.

It is expected that this project will develop a Statewide system of coordinated, comprehensive services and neglected elderly persons and their abusers which will deliver quality and cost efficient services to allievate the problem.

NATIONAL NUTRITION PROGRAM

Senator INOUYE. The Administration on Aging's longitudinal evaluation of the national nutrition program showed that costs per meal ranged from $2.07 and $6.03 with a mean cost of $2.82. What are the present data on that?

Mr. HANDELSMAN. The average cost per meal in fiscal year 1979 was $2.68 nationally. We have encouraged States to contain the cost of meals through management initiatives, such as improvements in purchasing practices, and more efficient delivery of the meals.

Senator INOUYE. What about the nutritional value of the meals?

Mr. HANDELSMAN. The law requires that each meal meet one-third of the required dietary allowance. We have found that through evaluations and other assessment activities the States are meeting that requirement.

ADMINISTRATION ON DEVELOPMENTAL DISABILITY

Senator INOUYE. I would like to now get to developmental disabilities. During last year's hearings, the chairman of this subcommittee expressed displeasure with the entire funding application and review process of the developmental disabilities program. What has been done to tighten up the utilization of the peer review process to prevent unwarranted disregard of peer review recommendations in order to fund apparently inferior grant applications?

Mr. MASTER. If I recall, that reaction was based on an incident that took place when the developmental disabilities program was part of the Rehabilitation Services Administration. There was some statutory provision that in effect created obstacles for the Assistant Secretary in the broader management of the agency to provide a check-and-balance system in the grants area.

Since that time the Administration on Developmental Disabilities has become an administration within HDS. The Rehabilitation Services Administration has moved to the Department of Education. In looking at this matter over the last several weeks, I satisfied myself at least that those kinds of practices no longer exist.

That is a general answer. I would like to ask Mr. Mottola, the Director of Management Services for the agency, to elaborate.

Mr. MOTTOLA. At the time the initial grant was awarded, we felt that there were some inappropriate actions taken but that the Commissioner was operating fully within his discretionary authority. Since that time, we have worked with the Administration on Developmental Disablities to look at the quality of the particular grant in question, to look at the programmatic progress that the grantee was making, and we have assured ourselves, as the Acting Assistant Secretary said, that the grant itself is producing good programmatic results.

We have also tightened up the review procedure in relation to the Administration on Developmental Disabilities, and we have gone through all of the procedural requirements for review of all of the developmental disability grants for fiscal year 1980, and we intend to do the same for fiscal year 1981 so that there are no shortcuts that can be taken and no serious distortions of peer review recommendations.

NATIONAL CITIZENS PARTICIPATION COUNCIL

Senator INOUYE. What is the status of the Inspector General's investigation of grants awarded the National Citizens Participation Council?

Mr. MOTTOLA. In our meeting with the Inspector General's office last week, we were informed that the investigation is still underway, and that they have no concrete results.

Senator INOUYE. What was the rationale for awarding the National Citizens Participation Council additional money while this investigation was still pending?

Mr. MOTTOLA. The rationale was pretty much as I described, Mr. Chairman. Programmatically, the grantee is performing very well in the opinion of the program experts in the Administration on Developmental Disabilities. We were aware of the audit and the investigation by the Inspector General.

There are two things going on in the Inspector General's Office. One is an audit, and the other is an investigation. We took the results of the audit to date, and the audit was not final—this was in September 1980—reviewed those with the Program Office of the Administration on Developmental Disabilities, and performed some on-site reviews of the grantee.

Our conclusion was that because the program was doing well and because there were no major problems that remained uncorrected by the grantee, that we had no reason for not funding that program for a second year.

Senator INOUYE. What action has been taken with respect to Senator Schmitt's request to Secretary Schweiker in a letter dated January 26, 1981, that further funding of the National Citizens Participation Council be withheld, pending completion of the Inspector General's investigation?

Mr. MOTTOLA. We have determined that we would not provide additional funding to the grantee until the results of the investigation are complete. Then we would take those in to account. The grantee will not be up for refunding until September 1981.

Mr. MASTER. As Mr. Mottola mentioned earlier, the report is not final yet. In meeting with the Inspector General's people last week, they indicated that they expect to wrap it up within the next month or so.

Senator INOUYE. Why was this investigation and audit initiated?

Mr. MOTTOLA. If I am not mistaken, it was at the request of Members of Congress.

CHILD WELFARE SERVICES

Senator INOUYE. I would like to move to child welfare, if I may. It has been suggested that the new child welfare services program is to be made part of a proposed social services block grant program. I presume this would mean that the incentive provisions of the Adoption Assistance and Child Welfare Act of 1980 would no longer apply.

Now if this happens, how can an improved standard of care for foster care children be guaranteed?

Mr. MASTER. Again, I don't know what would be in the details of that proposal. I assume that would be made public when the budget is published. I understand that will happen March 10. Until I see the details and exactly how that grant would be structured and whether this program would be included, I do not know.

Senator INOUYE. You indicated you have no idea until March 10. Are you suggesting to me that OMB has not conferred with you?

Mr. MASTER. A number of us have been consulted on the options. We are participating in those discussions.

Senator INOUYE. OMB has not made any indication as to whether it is up or down?

Mr. MASTER. I could guess. I can venture an educated guess at this stage of the game, but I am not at liberty to discuss that. Frankly, I think that would be speculation frankly on my part.

Senator INOUYE. Would you say that my source is good or bad? [Laughter.]

Mr. MASTER. I would say it is warm. [Laughter.]

Perhaps Tony Itteilag from the Department could speak to that as well.

Mr. ITTEILAG. Senator, I think it is fair to say that the block grant, as it will ultimately be proposed, will in fact give the States a great deal of flexibility. It is highly likely that the provision that you refer to in the existing law will no longer exist. I think it is fair to conclude that we cannot, in fact, give the States flexibility unless we give them flexibility.

From every indication that I have, it is that this will be a very, very flexible grant insofar as the proposal of the new administration is concerned. And then, of course, it will be the responsibility of the Congress to either approve that or to change it in a way that the Congress sees fit. But I feel very certain that it will be a very, very flexible proposal. The States will have a great deal of flexibility.

Senator INOUYE. Is it true that the child welfare services program was established because several States were doing a very, very poor job?

Mr. MASTER. In the mid- to late-1960's when the services began to be put into that title, I gather the States—at least as far as the Congress was concerned—needed some prodding.

Now 14 years later, the burden of the Public Law 96–272 is on another phenomenon that needs to be addressed, which is the direction in the foster care area. The bulk of that money again is spent by the States, not the Federal Government. It is largely State money. The Federal contribution would go to support State activities, and it is really just an incremental amount that would go in fiscal year 1981 to move into these new directions in turning the foster care system around, reuniting youngsters with their families.

Senator INOUYE. Do you believe that the Federal Government has done sufficient prodding so that now the States can take over?

Mr. MASTER. In this particular area, since 1981 is the first year, I would say unequivocally, "No." The message basically, I think, still needs to be communicated. And going back to Tony Itteilag's point, proponents of the block grant program would argue that it would be sufficient to get the message across, share the information, and let the States—assuming this were to be part of the program, make an informed judgment.

CHILD WELFARE RESEARCH

Senator INOUYE. For the past several years, Congress has appropriated several million dollars for research on child welfare. What are some of the findings of the recent child welfare research programs?

Mr. MASTER. Let me refer that question to John Busa, Acting Commissioner for ACYF.

Mr. BUSA. We have done a number of things in the area of child welfare research, particularly looking at ways in which the existing program services being provided by States could be strengthened. We have conducted extraordinarily successful research and demonstration efforts having to do with the provision of comprehensive emergency services to children as a way of preventing the initial breakup of the family, and removing the child from his or her home.

A very successful demonstration on comprehensive services was conducted in Nashville, Tenn. We have also conducted successful demonstrations dealing with how to reunite children with their families. We did a project, a very successful project, in Oregon dealing with permanency planning. We have also conducted a project in Ohio that looked at what might be done to improve our capability to increase adoptions of handicapped children.

These projects have been very instrumental in influencing, to some extent, the provisions that finally found their way into the new child welfare legislation.

Senator INOUYE. There has been much publicity about child abuse. I think the populace has become rather sensitive to it. However little is known about its root cause and the extent to which it pervades society.

CHILD ABUSE AND NEGLECT

What is the state of our knowledge about the incidence, causes, and characteristics of child abuse and neglect?

Mr. BUSA. We have recently completed a new incident study of child abuse. The final report is not yet in, but in general terms it appears that the incidence of child abuse and neglect in this country exceeds 1 million cases per year.

Senator INOUYE. How many?

Mr. BUSA. One million. We also know there has been a dramatic increase recently in the reporting of child abuse and neglect largely due to the child abuse and neglect program that we administer.

Senator INOUYE. What would you consider to be serious child abuse and neglect?

Mr. BUSA. In terms of the national incident study it was defined as abuse and neglect that resulted in observable and lasting harm to the child. Again, this estimate was based on a sample of States. We did the survey in 7 States, 26 counties, and the estimates obviously are projections of what you would find if you did it on a nationwide basis. It is still a very major and serious problem in this country. That much is clear.

Senator INOUYE. Is there any correlation between child abuse and the family's income?

Mr. BUSA. There seems to be some indication that poverty adds stress. It adds to the stress that may already exist in the family. There is some indication that the probability of being abused might increase as the family income goes down.

Senator INOUYE. Any correlation with educational background?

Mr. BUSA. Not that I know of.

HEAD START

Senator INOUYE. May we now go to Head Start. A February 1979 GAO study indicated that early childhood programs for low-income families can result in reduced health, social, and educational problems in young children that otherwise would be expensive and difficult to overcome in their later years. Other studies have come to the committee's attention that indicate that Head Start in particular has been cost effective in reducing the need for special education and remedial measures among children in their school years. What statistics does the Department have regarding the cost effectiveness of Head Start, and does it compare with other efforts or nonefforts?

Mr. BUSA. Head Start has been a highly successful program. It has been a program that works and all of the research evidence that we have on studies that were conducted by the administration for children, youth, and families, and conducted by others in the field showed the program is well worthwhile. One of the studies you may be referring to that recently came to everyone's attention in the media, is the study of a program in Michigan which showed that it was highly cost effective, to provide quality preschool education to children, both in terms of long-term effects on academic achievement, on reductions of placements of children in special classes or special education. There is some evidence to suggest also that it may have some impact on the probability that a youngster, in the future, as a teenager would be able to secure employment and maybe even reduce delinquent behavior. It is a very worthwhile investment we are making as a nation in providing these kinds of services to poor children.

Senator INOUYE. The administration has, I believe, announced that the Head Start program will not be cut. Does this mean that the $950 million suggested by the Carter budget is going to be kept intact?

Mr. MASTER. That is what we have inferred. That is what we would expect to see on March 10.

Senator INOUYE. Your source is reliable? [Laughter.]

Mr. MASTER. We'll find out on March 10.

Senator INOUYE. What would be the impact on services if Head Start were forced to operate under continuing resolution during fiscal 1982 at the $820 million fiscal 1981 appropriation level as compared to the $920 million proposed for fiscal year 1982?

Mr. BUSA. We would anticipate two impacts. One is that there would be approximately a 10-percent reduction in the number of children served. Two, we would not be able to implement qualitative improvements in programs that are suggested at the 950 budget level. That is to say, we would not be able to make improvements in reductions in class sizes. In addition to that we would not be able to take some steps to continue to attract and retain qualified people in the program. The salary levels are currently very low.

Senator INOUYE. How many States combine programs for Head Start children with other programs for preschool children?

Mr. BUSA. Senator, I can't give you a precise answer on that. There are obviously some Head Start programs where both Head Start and title XX funds are combined into one program for those children. There may be some other situations where they would be receiving funds from other Federal programs, but I couldn't give you a precise number.

Mr. MASTER. In the last year we did a very rough analysis for another activity that we were planning under Secretary Pat Harris, and we do have some information, not very rigorously arrived at, but we could share that.

Senator INOUYE. Fine.

ADMINISTRATION FOR NATIVE AMERICANS

Now I would like to get to native Americans. The committee was pleased to learn that the Commissioner of Native American Programs has been working closely with the Director of the National Institute of Mental Health to develop interagency agreements whereby many unique mental health needs of native Americans are addressed in a creative and responsive fashion. It is the committee's understanding that these special demonstration projects have been developed with native American organizations such as those representing native Hawaiians in order to insure that the services will be truly responsive to needs. The most-in-need project in Hawaii has been reported to have been especially successful. Is that so?

Mr. MASTER. Could you respond, Mr. Lester?

Mr. LESTER. We believe that the project is successful from a couple of standpoints. The most important is that it has a community base, and community people are becoming involved in solving their own problems. I think that is very critical, particularly in the native American populations. The other is that for the first time we have been able to approach a problem in a coordinated way and in a cooperative effort at the community level involving ANA, the National Institute for Mental Health, and State officials. We think this will result in changed behavior not only in the community but in agencies that are intended to serve the community members.

Senator INOUYE. In recent years, funds have been earmarked for native American groups. What proportion of the funds of the Office of Human Development Services are for Alaska Natives and for native Hawaiians, and how does this compare with other groups?

Mr. LESTER. I couldn't speak to the figures for HDS as a whole. Within the Administration for Native Americans, we have a budget of $33.8 million for 1981 earmarked, or designated to serve native Americans, which includes American Indians, native Hawaiians, and Alaskan Natives. Of our $33.8 million we have direct programs in Hawaii of $1,220,000 and in Alaska a little more than $1 million. We have other activities as well. We have gaps and barriers to service project in which we are working extensively in Alaska and Hawaii looking at a broad range of services that people need beyond social services. Looking at social services, protective services, fire protection, police protection and a wide range of health services. Basically what we are doing in that project is looking at the accessibility or availability of this service and also at the suitability of the service for the population in question. We also, of course, support these projects with training and technical assistance. The amounts that I quoted you are the amounts that we provide directly in financial assistance in Hawaii and Alaska.

Senator INOUYE. Mr. Secretary, I thank you very much. We have many other questions we would like to submit to you for your response, and if you can provide the answers at about the same time you return the corrected hearing transcript, we would appreciate it very much.

[The following questions were not asked at the hearing but were submitted for response for the record:]

Questions Submitted by the Subcommittee

TITLE XX SERVICES

Question: Are there any services you know of that States provide with title XX funds that the Federal government does not offer in one of its categorical programs? Can you give us any examples?

Answer: Title XX of the Social Security Act provides States with the flexibility to define services and their components as the State finds useful for its social services program. Indeed, there are over 1,100 different titles in the 51 States' (including the District of Columbia) Comprehensive Services Program plans. The definitions and their components vary widely and are similar in many instances to the service definitions in categorical programs. We are aware of no services to large numbers of persons that States provide exclusively with title XX funds.

However, while many of the services funded with title XX funds are similar in definition and service components to services offered by categorical programs, this does not mean that the service itself is available to the same populations. Categorical programs are targeted to certain populations or to individuals with certain conditions, such as the elderly, children, the handicapped, the mentally ill, and drug or alcohol abusers. In the title XX program services provided vary from State to State and frequently within the States in different geographic areas. This makes it possible for each State to tailor its social services program to meet the unique needs of individuals who might not meet the eligibility criteria of the categorical programs in areas where the need is greater than the funding available through those programs.

Question: Specifically, what family planning and home care services are provided under the title XX program that are not provided by other programs--such as Medicaid and Health Services Administration Home Health Programs?

Answer: To our knowledge, there are no family planning or home health services exclusively provided by the title XX program.

However, family planning provided under title XX, which at State option can be provided without regard to income, is usually available to a broader population that is available under the Medicaid program. In addition, in 30 States family planning services are coordinated between the title XX and the Medicaid programs. In these States, information referral, education, and counseling are provided by the title XX program, while the actual medicare procedure is provided by the Medicaid program.

Under title X of the Public Health Service Act, funding for family planning services is extended to public or private non-profit agencies who may service broad population. However, the emphasis among the grants extended is on agencies servicing the teen-age population. Under title XX, States may contract with private agencies and/or arrange for the delivery of services for particular clients in whatever local agency the service is available.

The title "home care" may cover both personal and health-related services. This possibility highlights the primary differences between home care services extended under title XX and through the Health Services Administration (HSA).

Under HSA, provider agencies receiving grants must limit social services to individuals who are receiving a medical service. The grants are made directly to agencies for capacity-building purposes only and all agencies must meet Medicare certification requirements in order to be funded.

None of these conditions apply to home care services under title XX. Indeed, home care services are extended for social service needs, and medical services are provided only if that service is integral but subordinate to the social service. The services thus provided appear to be complementary to those provided by agencies funded by HSA in terms of individual service requirements.

In addition, under title XX, States may target these services to specified population groups, e.g. the elderly or other persons with incomes below a given level, and may provide funds for these services as long as the State perceives a need for such services.

STATE AND LOCAL TRAINING

The budget for Title XX State and Local Training has been capped by Congress since FY 1980 at $75 million.

Question: How has this affected the number of people trained under this program?

Answer: In a recent pilot project of a training program management review a total of 10 States (1 in each region) were reviewed. The data gathered in the review indicates that all States in the survey are reducing in-service training for staff in such areas as new skills in service delivery and management training; reduction in or delays in grants/contracts with educational institutions, whether for long-term or in-service training. For example, 1 of the States reduced all grants to educational institutions from a total of $639,000 to $180,000. At least 3 of the States eliminated "preparation for employment" during FY 1980 and 2 eliminated their educational leave program. Finally, the majority of these States surveyed indicated that their programs would be shifting predominantly to the minimums in in-service training for staff and face the dilemma of improving/enhancing skills of staff at all levels in the organization.

Question: What estimates does the Department use to calculate the need for training funds?

Answer: The Department uses the State's quarterly expenditure report for the prior year and the State's quarterly estimate of expenditure for the current year to develop the budget for training. Variables taken into consideration include charges (increases or decreases) in the training program trend in States, the known new or proposed legislation (new Federal/State program) that may require development of new personnel or retraining of current staff. In FY 1982, the States will be submitting Training Plans that will be used in formulating amounts of Federal funds States will receive.

Question: What sorts of training does this program provide?

Answer: The title XX State and Local training program provides orientation and in-service training for employees of the State and local title XX agency in all classes of positions and to the service delivery and eligibility personnel of provider agencies with current purchase of service contract to establish eligibility and to provide service(s) to Title XX eligible individuals; also, training is provided to individual providers under contract to the agency.

In 1978, latest data available supplied on a voluntary basis by 35 States and projected to national figures, approximately 350,000 individuals received in-service training. In rank order training was provided in specialized training for delivery of a specific service, service-related skill training, policy interpretation and other management functions.

Employees of the Title XX agency and eligible employees of provider agencies may be granted educational leave to pursue degree oriented programs at post secondary, undergraduate, and graduate educational institutions. A legal commitment to return to the agency to work for at least a period equal to the period for which financial assistance has been granted is required.

Persons preparing for employment (non-employees) in the Title XX agency may be awarded financial assistance to pursue educational programs (approved by the Title XX agency) at educational institutions. Such students must have a legal commitment to work for the agency for a period of time at least equal to the period for which financial assistance was granted provided the State agency offers the student a job within 6 months after his training is completed.

Grants for short term or long term training may be made to educational institutions to develop curriculum, for classroom instruction, and field instruction for the purpose of developing, expanding, or improving education/training to meet the manpower needs of the State Title XX program.

A provision in the Child Welfare Amendments allowed States to accept restricted private donations for training.

Question: What exactly does this mean?

Answer: P.L. 96-272 provides in Section 204 that in fiscal years 1980 and 1981 funds may be donated to the State agencies specifically for the purpose of training and retraining if such training or retraining is done by public or nonprofit entities. This means that the donor can be a sponsor or operator of a training program (for example, an educational institution) and may place other restrictions on the use of the money; such as, the money is to be used for training programs in the donor's facility.

Question: How much restricted private money was donated in FY'80?

Answer: No data is available.

Question: What restrictions, if any, are placed on this money?

Answer: There are no restrictions on the money beyond those imposed by P.L. 96-272: 1) that the money donated is to be used for training and retraining and 2) that such training is carried out by a public or nonprofit entity.

THE WHITE HOUSE CONFERENCE FOR CHILDREN AND YOUTH

Question: What is the status of planning for the December 1981 White House Conference for Children and Youth?

Answer: The White House Conference is in its planning and conceptualizing stage and is currently engaged in goal setting and overall planning. Public Conference activities are scheduled to begin on or after April 1, 1981.

Question: What has been accomplished so far?

Answer: To date the Conference staff has been generating, developing and refining a series of option papers that deal with every phase of the White House Conference's proposed operation. These include, but are not limited to, issue development, outreach alternatives, press and public affairs, delegate selection and overall critical pathing for Conference events.

Question: What remains to be accomplished?

Answer: After completion of the planning and conceptualizing stage, the White House Conference will begin to implement plans for an innovative, creative and participatory Conference designed to share positive solution-oriented information with American children, youth and parents.

Question: Will it be necessary to request a supplemental appropriation, or will the $3 million provided in Fiscal 1980 be sufficient to complete all Conference activities?

Answer: The Conference will not request a supplemental appropriation.

Question: What will the format be?

Answer: The White House Conference format is based on a two-track model designed to maximize participation from a broad cross-section of American citizens. One track will be identifying professional expertise, delineating concern areas and preparing materials for other Conference participants. The other track will be identifying, selecting and preparing Conference delegates for their important discussions. Both tracks will converge during the Conference in December and result in positive information-sharing between the experts who have devoted their professional lives working with the real experts -- children, youth and parents.

Question: What lessons could be learned from the recent White House Conference on Families, to avoid the well-publicized difficulties and controversies that the Conference encountered?

Answer: Careful selection of concerns capable of solution by the Conference participants themselves, delegate selection that is open and innovative and a nonpolarizing educational Conference format can avoid the difficulties that have plagued a number of past White House Conferences.

Question: How many Conference staff are there?

Answer: Currently, there are 19 full and part time staff on the White House Conference payroll. Of these, 10 are professional staff and 9 are support staff.

Question: How many are career civil servants?

Answer: All staff positions at the Conference are in the Excepted Service (Schedule A).

Question: How many are Carter appointees?

Answer: There are no Carter appointees serving with the White House Conference.

Question: How much input will the Reagan Administration have in appointing staff and setting the Conference agenda?

Answer: Executive Director Richard Eyre has had two detailed conversations with Secretary Schweiker who, pending White House input, has agreed on the direction for the Conference. A wide variety of organizations and individuals will have input in the planning of the Conference. The Reagan Administration, Secretary Schweiker and Members of Congress will continue to have full access and input as Conference planning and administration go forward.

Question: How much money was spent on the Conference in Fiscal 1980?

Answer: In Fiscal Year 1980, the Conference spent $127,812.

Question: How much will be spent in each of Fiscal Years 1981 and 1982?

Answer: The Conference expects to spend $2,310,398 in Fiscal Year 1981 and $561,790 in Fiscal Year 1982.

Question: What will be the procedures for the Conference?

Answer: Procedures for the Conference are still in formative stages. It is envisioned that Conference activities will be based on nonpolarizing concerns capable of resolution which will be discussed in an educational and conversational format.

Question: How will the States participate?

Answer: It is expected that states will participate not only by staging state and local activities and identifying Conference participants, but by staging a wide variety of self-initiated creative, cultural and educational programs designed to share ideas with fellow citizens.

Question: How will delegates and topics for discussion be chosen?

Answer: Delegates will be chosen based on their initiative, drive and creativity and will have several channels of nomination and self-nomination. Concern areas will be identified by delegates and public opinion research and will focus on private and voluntary sector efforts.

Question: Who will attend the National Conference?

Answer: The White House Conference in Washington scheduled for December 13 - 18, 1981, will be attended by delegates, special delegates (experts, national organization representatives, media representatives, etc.) and guests such as the President and other public officials.

NATIVE AMERICAN GOALS AND STRATEGIES

Senator Inouye: Mr. Lester, I have been impressed with the programs the Administration for Native Americans offers. Specifically the fact that Native Hawaiians are eligible for these programs as are non-recognized Indian tribes and urban Indian centers. Can you tell me what ANA's goals and objectives are for FY 1982 and how you see these goals and objectives being implemented?

Answer: Yes, Senator Inouye, ANA is the only Federal Native American program which serves all Native Americans without regard to where they live or their tribal or group affiliation. As you know, within this constituency is a wide diversity as to language, culture, legal status, size, resources and eligibility for services. This includes terminated Indian tribes, non-Federally recognized Indian tribes, state-recognized tribes, isolated rural non-reservation communities, urban communities, and other Native American groups that have organized for specific purposes. The latter category includes the 12 recognized regional and numerous village corporations organized in Alaska since 1972, and Native Hawaiians, who created a private, non-profit corporation after they were defined as Native Americans by Congress in 1974.

I believe that the diversity of our service population is a good lead-in to both our mission statement and our goals and objectives.

ANA has one aim: to promote social and economic self-sufficiency among American Indians, Alaska Natives and Native Hawaiians. To carry out this mission, we have three main goals for FY 1981 and FY 1982:

- developing tribal and community institutions and Native American leadership in ways that enhance the capacity for Native Americans to influence their social environments and the services to which they are entitled;
- fostering economic development, especially the development of Native American resources, including, but not limited to, reasoned development of the known energy resources held by 25 tribes. We believe that progress in economic development is crucial to relieving the acute and chronic social problems found among Native Americans; and finally;
- encouraging the elimination of gaps in services which result from the diversity of the constituent population, jurisdic-

tional ambiguities, unclear areas of program responsibility, fragmented program efforts, and actual discrimination.

You asked how our goals are being implemented. Because of the diversity of our service population, there is no set formula from Washington that can get this job done. We act on our firm belief that the local community is to be responsible for determining its own needs and priorities and for implementing the programs to achieve self-sufficiency. We carry out our goals through policies and programs which support the Federal policy of Indian self-determination where it is appropriate. That is, where we are dealing with Federally recognized tribes and tribal governments which are an integral part of the country's Federal system of shared sovereignty and responsibility, we act to strengthen tribal governmental institutions to help tribes meet their responsibilities and obligations to their members.

In cases where the explicit policy of Indian self-determination is not appropriate, we nonetheless, foster local control and decision-making. Thus our strategy for accomplishing our basic program objectives -- through financial assistance, research and demonstration, and training and technical assistance -- is also three pronged:

- o We support a planned, comprehensive, community-determined approach to social and economic self-sufficiency.

- o We actively promote coordination of efforts throughout the Federal government and in the private sector to enhance self-sufficiency. For example, we initiated or were involved in more than 30 interagency program initiatives in FY 1980.

- o Finally, we work to increase our own inhouse capacity to plan, manage and collect and disseminate information in order to assist local Native American efforts, on and off reservations.

Senator Inouye: What is the basis of ANA's "Social and Economic Development Strategies Initiative" and how does it differ from programs administered by the Bureau of Indian Affairs in the Interior Department? How does ANA coordinate its efforts with other agencies?

Answer: ANA operates on the principle that economic and social development are inter-related and that both must be balanced if Native Americans are to achieve self-sufficiency. Let me explain what has happened in the past. Some tribes have focused on economic development more than social development without realizing the potential for exploitation from non-Indian developers and the social chaos when community services don't keep up with population booms. Other tribes have focused on social development, primarily seeking badly needed services -- health care, social services, housing, and the like. This has led, in part, to a serious dependency on services.

Through our Social and Economic Development Strategies we are trying to encourage our grantees to achieve a more balanced approach. What we call SEDS is not a program, but an approach, a way of focusing on barriers to self-sufficiency. SEDS moves the focus from increasing consumption, as in the case of social services, to increasing production, as in the case of creating a climate for economic growth which will provide jobs and mechanisms for self-support. Obviously, only the local community knows what blend of activities is required to create the needed social and economic balance. Native American leaders from all over the country helped create the SEDS approach.

ANA believes that lasting social and economic progress requires local coordination that directs all resources (Federal and non-Federal) toward the locally-determined priorities. We believe tribal leaders should have better control over the grants and contracts which come onto the reservation. The local leadership, on or off the reservation, should determine what programs should be in the community.

Thus, we are concerned, as an example, with strengthening the executive functions of the governing bodies of Indian tribes to make appropriate decisions and to take charge of social and economic growth.

In keeping with SEDS, tribes are currently implementing a variety of activities to strengthen their planning, managerial, fiscal and judicial functions as units of government with responsibility for serving their own members. A strengthened tribal government can make decisions to control development and respond to the demand for additional schools, roads, businesses, health care and social services.

The SEDS approach -- and in fact, the overall ANA approach differs distinctly from that of the Bureau of Indian Affairs. BIA has the lead in carrying out the Federal government trust responsibility to recognized tribes. As an agency, BIA provides greatly needed services to tribes. ANA is a catalyst and advocate, its funds are flexible, and it serves every group identified as Native Americans. BIA strengthens tribes as a mechanism for administering BIA. ANA operates on the premise that no Federal program by itself--or any combination of Federal programs--can assist Native Americans achieve self-sufficiency. Native Americans must design, plan and operate their own programs. It is ANA's purpose, through approaches such as SEDS, to strengthen tribes and local communities to do just that.

You have also asked how ANA coordinates its efforts with other agencies. Our legislation sets the stage for such coordination and prohibits us from duplicating the efforts of other agencies. We are the agency which holds out the goal of Native American self-sufficiency. We are a long way from the realization of the ideal, as Native Americans are still at the bottom of almost every measure of social and economic well being.

We do, however, open up avenues of communication not only within the entire Native American community, but within the family of Federal agencies which relate to Native American populations in a variety of ways. By encouraging cooperation, we are able to avoid duplication in funding and programs and to allocate and manage Federal resources in the most cost-effective way.

The formal expression of this cooperation is the interagency agreement. Among the 23 or more agreements currently in place, here are a few examples:

- We support a project enabling the All Indian Pueblo Council in New Mexico to provide coordinated delivery of training and technical assistance to 19 Indian tribal governments, in cooperation with the Indian Health Service.

- With the National Institute of Mental Health, we support the "Most in Need" demonstration project, which coordinates resources on behalf of Native Hawaiian children and youth.

- We are cooperating with the Department of Labor and the Indian Health Service in helping tribal governments develop the capacity to control the environmental health impact of development activities on their land.

Thus our mission is self-sufficiency and our goals, strategies and interagency coordination lead us to that end.

Senator Inouye: Do you have information as to how ANA has increased the management capacity of Native Americans and Tribes?

Answer: Yes, we do have evidence that this is taking place. For example, an in-house evaluation based on a comparison of 1976 and 1978 performance data for 56 Indian reservations clearly revealed that significant progress has taken place in planning and management by the majority Indian tribal governments supported by ANA. The highest degree of overall improvement (average of 80.9%) recorded during this period was in the area of program management, particularly in areas affecting compliance and performance accountability. These were also the areas where the greatest needs then existed. While some ANA grantees still require assistance in these areas, the evidence indicates that many have arrived at a stage of development where they are ready to assume a more complex and specialized form of management skill, for example, planning and implementation of community-determined socio-economic development strategies. Accordingly, ANA has refocused its program effort in order to address this emerging need in a timely fashion -- through the Council for Energy Resource Tribes, special supplementary grants, and the Tribal Employment Rights Planning Committee, for example. We also have a major technical assistance effort underway in conjunction with the Office of Personnel Management. One ANA grantee, the Inter-Tribal Council of Nevada, recently won one of the four national OPM awards for excellence -- the highest award in the state or local category.

Senator Inouye: What would you state are your most successful projects funded to date?

Answer: Let me give you a few of our many success stories:

First, ANA has joined with other organizations, public and private, to strengthen the governing capacity of the 25 tribes which created the Council of Energy Resource Tribes, popularly known as CERT. These tribes own significant amounts of the nation's coal, oil, gas, oil shale and other energy resources, largely in an undeveloped state. Tribal chairpersons make up the

CERT Board of Directors. CERT assists their members in using their energy resources as a base for establishing stable economies, in protecting their natural and social environments, and in undergirding tribal governments to adequately manage its energy resources. These three goals are totally compatible with those of ANA. ANA funded $644,000 to CERT for FY 1980.

For 1980, CERT reported a total of 188 activities specifically tailored toward technical assistance, analyzing and planning activities and strengthening tribal energy management capabilities. Here are two out of 188 possible examples:

- CERT worked with the Crow Tribe to complete a preliminary assessment of the oil and gas potential on its reservation. Preliminary estimates of production capacity are in the range of 10-20 million barrels of oil.
- CERT prepared an analysis of the possible alternatives available to the Ute Mountain Ute Tribe for economic development of abandoned oil wells on the reservation. Potentially, this could mean the production of 3,000 barrels of oil a day and a substantial flow of revenue to the tribe.

One of ANA's successful undertakings has been a 4-year-old multi-agency Indian employment initiative which has resulted in the establishment of Tribal Employment Rights Offices (TEROs) on reservations. A Tribal Employment Rights Planning Committee funded by ANA and the Department of Labor, supports the TEROs with know-how, training and the dissemination of information. The TERO project has been extremely successful in helping tribes use their authority to enforce Indian Preference on the reservation and to take steps to end discrimination in public and private hiring near the reservation. Employment of Indian people on reservations has at least doubled and in some places tripled as a result of TERO negotiations with contractors and employers on or near reservations. Since last year, the number of TEROs has increased from 25 to 39; including seven in Alaska, and many more are now being formed -- 20 in the State of New Mexico alone.

Another of our successful grantees, Senator, is the Three Affiliated Tribes of Mandan, Hidatsa and Arikara on the Fort Berthold Indian Reservation in North Dakota.

In FY 1980 the tribe's funds were increased to a total of $406,085, a little over 200 percent, through a competitive award process to increase its developmental activities and enhance its management capabilities.

The tribe is pursuing an array of activities which are already paying off. It has reorganized and restructured its administration with an emphasis on planning. The comprehensive planning efforts have enabled the tribe to improve proposal/grant writing capabilities, using clear, concise language readily understood by community residents. This division provides a means of generating and collecting reservation information for planners and programs within the structure of the Three Affiliated Tribes' administration.

Interpreting and disseminating this information is a vital function. With demographic and economic data collected, this division can assess community development needs and help provide leadership and support for community activities. The tribe has shown the willingness to accomplish its highest priorities and then move onto new activities. Through ANA, the tribe has been able to draw on resources not previously available. The Three Affiliated Tribes are active members of CERT which provides technical assistance and training to its members. They have a most active Tribal Employment Rights Office which assists in rightfully protecting job rights for Indians. Coopers and Lybrand, a technical assistance contractor conducting an indepth evaluation of training and technical assistance on Indian reservations, is also working closely with the tribal government. Tribal members are also receiving benefits from the United Tribes Educational Technical Center in Bismark, also supported by ANA. The tribe's new approach has resulted in a streamlined management and savings of $100,000 which they turned back into services. As you can see, what may have once been an inactive, dependent tribe is now an active, involved and developing nation, seeking and working toward the day of social and economic self-sufficiency.

Senator Inouye, I would like to use your own State of Hawaii as an example of where important inroads are being made. Alu Like, Inc., a 5-year-old non-profit Native corporation is the chief recipient of ANA funds in Hawaii. This organization has established centers on each of the five major islands and has made gains in employment, health and education and other critical areas by mobilizing support from a variety of state and Federal sources.

In another example, Native Hawaiians on the Island of Molokai formed a farmers cooperative several years ago when Native homesteaders needed to return their lands to productive use following the phaseout of the pineapple industry. If the homesteaders don't succeed in their farming, their lands will be returned to the state. They would then have no place to live and no place to go. Last year ANA awarded Hikiola, the struggling co-op, $100,000. Hikiola hired a new general manager, who, working with the board, has been able to purchase fertilizer and supplies in volume and has strengthened the co-op's services to members. The farmers have been able to expand into alfalfa production -- needed by the state's dairy industry and usually purchased from the mainland. With a ready market, alfalfa is becoming the principal crop and the co-op and its members are on the road to success.

Senator Inouye: The Chairman of this Subcommittee was unfortunately unable to be at this hearing but I am certain he would like to know how ANA has affected the Tribes in New Mexico. What can you tell us about that?

Answer: I am glad to explain what is happening in New Mexico as a result of ANA efforts. Our office provides funding, directly or indirectly, to virtually every Indian tribe in the State of New Mexico. For FY 1980, almost $2 million in ANA dollars were provided as direct or indirect funds to 22 tribes and 3 urban Indian Centers. In addition, ANA provided another $4.8 million to the Navajo Tribe which, of course, lies in part within the State of

New Mexico.

Two consortiums are funded in the State: Six Sandoval Indian Pueblos with its tribal members of Jemez, Cochiti, and Sandia, and Eight Northern Indian Pueblos Council with its member tribes of Tesuque, Nambe, Pojoaque, San Ildefonso, Santa Clara, San Juan, Picuris, and Taos. Laguna, Isleta, Zuni, Acoma, Santo Domingo, Jicarilla and Mescalero are each funded separately.

These developing tribes have begun to use ANA funds as a means to build and strengthen tribal governments and those institutions for service delivery of tribal resources. As an example, we find that within the 22 tribes provided funds, there are 20 Tribal Employment Rights Offices now being formed -- each developing the capability to provide jobs on reservations for Indians -- jobs which are rightly theirs. We also find that six of the tribes are among 25 members of CERT and are thus receiving technical assistance in developing and protecting the tribal energy resources.

The activities of New Mexico's tribes run the gamut from developing Native products such as adobe blocks to be sold for home building to developing tribal capability through planning and goal-setting. The future is just beginning for many tribes which now see that social and economic self-sufficiency can be a reality -- with local capacity-building made possible by ANA support.

URBAN PROGRAMS FOR NATIVE AMERICANS

Question: I understand the Administration for Native Americans extends its program assistance to urban Native Americans. Can you tell me whether these urban programs are primarily referral services to assist Native Americans in applying for aid available to all Americans, or whether they are programs specifically designed to assist Native Americans?

Answer: The off-reservation projects which we finance, both urban and rural, are community-based organizations that carry out a wide range of activities to support Native American self-sufficiency. Urban Centers run programs just for Native Americans and also make referral to services such as health clinics and nutrition for the elderly that are available to all Americans. For reasons of inaccessibility or a lack of awareness, Native Americans frequently do not avail themselves of these services. ANA encourages Indian centers to establish or continue links with other service providers in the community. ANA urban grantees provide transportation or outreach or referral to assist Native Americans to gain access to this aid.

But that process goes well beyond referral -- it encourages Indian citizens to get involved in the community -- on the boards and on the commissions where decisions are made which affect the whole community, including those who are Native American.

In addition, ANA off-reservation grantees administer programs for the sole benefit of Native Americans -- programs which meet their special needs. Over 80% of off-reservation grantees operate

CETA Title II programs. Many also run adult education programs under Title IV of the Indian Education Act. Some have Indian alcoholism programs located in their centers.

In the past, urban grantees have tried to get more and more social services for community members. Through ANA's Social and Economic Development Strategies, ANA is encouraging urban grantees to work on reducing the need for such services by stimulating economic progress through business development and job creation. For example, in Tulsa, Oklahoma an Indian Chamber of Commerce was established to stimulate greater activity and growth in Indian owned enterprises. Other urban centers are engaged in similar activities.

Question: Could you describe some of your urban Native American programs?

Answer: Yes, here are some examples. The Council of Three Rivers American Indian Center in Pittsburgh, Pennsylvania was established in 1972 to assist the approximately 2,500 American Indians who reside in and around Allegheny County. The community through the Center has been very successful in gaining access to a wide range of Federal programs and in planning and putting into operation discrete projects that complement or fill in holes in these Federal programs.

The transportation system, for example, augments the Center's elderly, employment, health, and education programs by bringing Indians scattered throughout the county to the Center or to other agencies for services.

One of the strongest suits of the Center is its ability to work with state, local, and private providers to increase the access to and quality of programs to Native Americans. Its successful interactions and advocacy with school officials, for instance, permits the Center to operate a CETA program for Indians in 61 counties in Pennsylvania and in the entire State of West Virginia. Without a partnership between the Center and educators, the program could not succeed.

In Portland, Oregon the Urban Indian Council established the Native American Business Alliance, a private non-profit organization that assists Indian-owned businesses by providing management support and training. Advisory teams comprised of volunteer management, legal, planning and financial experts help Portland Native Americans in every aspect of entrepeneurship from marketing studies to labor relations.

Additionally, the Council operates a full service health clinic, legal services and day labor programs.

As another example, the Cook Inlet Native Association in Anchorage, Alaska operates twenty-five programs to meet the social, cultural and economic needs of the 12,000 Alaska Natives and American Indians in the region. The Association got its start with an ANA Community Services Program. Since then as the Association's credibility with Federal and state agencies has grown, so too has its budget. It is now a multi-million dollar operation.

The Association increased the services available to Native Americans by entering into cooperative arrangements with public and private providers and by providing auxillary services such as transportation and outreach and referral.

Question: Do you know if your programs for urban Native Americans comprise most of the Federal assistance to these populations or are there other agencies engaged in substantial assistance programs to urban Native Americans?

Answer: For most urban and rural off-reservation grantees, ANA funds make up the smaller part of their total budgets. Yet for most grantees, ANA dollars are critical. I don't imply here that these community organizations would wither and die without our funds, but the loss of ANA dollars would certainly narrow the approaches communities could take to achieving self-sufficiency.

This year, for example, a small tribe in Connecticut -- the Mashantucket Pequots -- will get $15,000 from ANA. Small stuff compared to what they get from HUD and the Department of Labor, but it pays for the tribe's share of an experienced community developer to help the tribe develop a gravel quarrying operation, expand fledgling aquaculture and maple sugar industries, and erect additional housing units. The prospects for full employment of tribal members in tribal owned enterprises is very good, but in order to realize this, they need the experience and expertise that their other monies cannot buy.

The Cumberland County Association for Indian People in Fayetteville, North Carolina has an annual budget of nearly a half million dollars of which ANA's part is $63,000. Using ANA funds the Association embarked several years ago on a planning and resource development effort that has resulted in transportation, nutrition, employment, education, recreational, and cultural programs that are addressing the needs of the Indian community in Fayetteville. Additionally, the advocacy efforts financed largely by ANA have resulted in establishing an Indian presence in over 20 community boards and advisory committees. Their ANA-supported negotiation with the County Commissioners and School Board resulted in a lease agreement that permits occupancy of a large school complex for $1.00 a year.

Question: How much was spent for urban Native American programs in Fiscal 1980, and what are estimated expenditures for each of Fiscal Years 1981 and 1982?

Answer: ANA spent $6,354,000 for urban Native American programs in FY 1980. It is estimated that $5,920,000 will be spent in FY 1981. With regard to FY 1982 estimated expenditures, the budget amount for this program activity is currently under discussion. After the revised budget is forwarded to the Congress by the President, we will provide an appropriate answer to this question.

NATIVE AMERICAN JOINT FUNDING PROJECTS

Question: The Federal Domestic Assistance Catalog description of Native American programs refers to Joint Funding projects. What programs, with which agencies, have you been carrying out under the Joint Funding authority?

Answer: In FY 1980, only one of our grantees requested assistance from ANA under the legislative authority of the Joint Funding Simplification Act. The Salt River Pima-Maricopa Indian community in Arizona received funds from Head Start and from ANA under a single grant. ANA funds were used to support the community's Office of Management and Program Development. In previous years, projects supported by the Department of Housing and Urban Development and the Law Enforcement Assistance Administration were also included in this Joint Funding Project. For fiscal year 1981, the Salt River Indian community has decided to deal with each agency individually rather than to continue the Joint Funding Project.

ANA supports the purposes of the Joint Funding Simplification Act, which includes reducing grantee administrative burdens and combining resources from several agencies to support projects of common interest. We have pursued these goals under interagency agreements as authorized by our current legislation.

Question: How much was expended in the past fiscal year for each of these programs?

Answer: The Salt River Indian Community Joint Funding Project included $209,695 from ANA and $122,085 from Head Start, for a total of $331,780 in fiscal year 1980.

With regard to the 23 fiscal year 1980 interagency agreements; ANA transferred $1,392,182 to other agencies under 17 agreements, and $1,141,308 was transferred from other agencies to ANA under 6 agreements.

Question: What percent of the total programs were represented by Administration for Native Americans funding?

Answer: ANA's share of the Salt River Joint Funding Project was 63%. Our share of interagency agreements varied with each individual agreement.

COST EFFECTIVENESS OF NATIVE AMERICAN PROGRAMS

Question: Your Department provides grants which, according to the Catalog of Federal Domestic Assistance, "may be used for such purposes as, but not limited to: projects aimed at increasing the capabilities of Native American groups to provide services for its members; projects designed to provide needed services to promote individual, family, and community self-sufficiency; provide for the establishment and operation of Native American human services centers and research projects on Native American issues, including collection of data to improve services to local Native

American communities; and provide self-help and community economic development efforts." Can you identify the Native American programs you administer and give some indication of which you consider the most, and which the least, effective?

Answer: ANA supports three basic program elements, which reflect our legislative authority. These are: Financial Assistance for Native American Projects under Section 803, Technical Assistance and Training under Section 804, and Research, Demonstration and Pilot Projects under Section 805.

The Financial Assistance projects enable Native American organizations to build and strengthen their governing bodies and other social and economic institutions, and to manage, coordinate, and ensure access to necessary services. Technical assistance and training helps develop necessary skills and supports Native American organizations' efforts to achieve their development objectives. Research and demonstration activities are carried out in cooperation with local communities and can be used by them for improved planning and program development at the local level. Projects carried out under these basic programs are aimed at our three major program goals.

Indian tribes and other Native American organizations are at various stages in the development of their capacity to manage and control the resources and programs they need to progress towards self-sufficiency. Basic foundation building must be accomplished before more effective efforts can be undertaken successfully. Each ANA project deals with the community at its level of need.

Our most effective programs are those which support capacity building. For ANA, capacity building goes beyond developing a good accounting system. It also means assisting the community to develop a coherent approach to reach social and economic self-sufficiency. This includes assisting the community to make the maximum use of whatever resources are available, directing those resources at the opportunities, and overcoming problems which stand in their way. Almost all of our programs are carried out in support of these basic purposes.

Our least effective programs are those in which we try to fill service gaps by funding direct service delivery. In the first place, the service needs are too great for our limited budget to meet many of them. We could easily direct all of our resources into meeting essential human service needs. But the structural problems would still remain. What we are trying to do is to help communities to develop their capabilities, to develop strategies, and to mobilize other resources to eliminate or reduce those service gaps without using ANA funds directly to provide services.

Question: Can you provide a breakdown of expenditures for each of these programs in fiscal year 1980?

Answer: In fiscal year 1980, ANA expended $29,850,077 for Financial Assistance; $2,413,988 for Training and Technical Assistance projects; and $1,535,935 for Research, Demonstration and Evaluation. Our total budget was $33,800,000.

CHANGE IN DEFINITION OF DEVELOPMENTAL DISABILITY

The 1978 amendments changed the definition of the term "developmental disability" from one specifying impairments or disorders to a definition based on the inability to perform major life activities.

Question: What have been the major effects of the definition change and how has this change impacted upon State planning, service delivery, and the protection and advocacy systems?

Answer: The major effect of the change in the definition has been the focus on the substantiality of an individual's functional limitations and the extent of which an individual requires multiple services. It is the pervasive quality of the disability which contributes support. As was pointed out by the National Task Force on the Definition of Developmental Disabilities, many individuals were inappropriately labeled "developmentally disabled" under the previous definition simply because they fell into the four designated categories of conditions, despite the fact that they did not meet the other criteria of the definition. The 1978 functional definition simultaneously expands the categories of conditions which might be considered within the developmental disabilities population while narrowing the focus on the substantiality of the disability and the need for services.

In terms of the impact of the change on the program components, the response to the change has been mixed. During the initial implementation of the new definition, the State planners were concerned with estimates of the target population in term of: who, how many, and identifiable service needs. Most States developed mechanisms to address these concerns, some utilizing the materials developed for the Administration on Developmental Disabilities, in their development of State plans.

There was also a concern that the definition would result in a larger number of individuals to be served with already inadequate funds. However, this concern lessened somewhat as the planning process continued and the size of the population generally decreased due to the emphasis on the substantially handicapped.

The effect of the definition on the protection and advocacy system is an increase in the number of developmentally disabled individuals served who do not fall in the previous four categories of conditions. It must be remembered, however, that the number of individuals served by the protection and advocacy system almost doubled between FY 1978 and FY 1979.

Question: Have any States complained that the definition has resulted in confusion regarding service eligibility?

Answer: There is no consensus about the case or difficulty of eligibility determination under this definition. The perspective varied from State to State and between planners and service providers. However, many States already had put in place some sort of functional limitation requirement for determining eligibility so that when the 1980 Notice of Proposed Rule-making requested comments from the States on their experiences in implementing the federally unelaborated definition from the law, the respondents were evenly divided between those who had structures in place and needed no further guidance and those who did need guidance.

The most significant issue related to eligibility determination to arise is the controversy around amending the current definition of "persons with related conditions" in the Intermediate Care Facilities for the Mentally Retarded regulations which is tied to the developmental disabilities laws. The use of the functional definition in the Medicaid Intermediate Care Facilities for the Mentally Retarded program has the potential for including many new categories of conditions not previously included, such as the chronically mentally ill.

Developmental Disabilities Protection and Advocacy Programs

Question: Has the Department issued specific regulations and guidelines for the Protection and Advocacy Program under the Developmental Disabilities Act?

Answer: Yes. A regulation implementing P.L. 94-103 covering the Protection and Advocacy Program, Basic State Grant program, Special Projects and University Affiliated Facility program was issued in January 1977. Protection and Advocacy program guidelines covering the operation of State Protection and Advocacy systems were subsequently issued.

A proposed regulation which implements changes in the Developmental Disabilities program stemming from the passage in 1978 of P.L. 95-602 are currently under review by the Department of Health and Human Services.

Question: What has the Department done to ensure the coordination of the Protection and Advocacy activities of the State Formula Grant Programs?

Answer: The Administration on Developmental Disabilities has actively promoted the coordination of Protection and Advocacy program activities through special project grants during each year of State Protection and Advocacy operations. In each year since FY 1978, a national Protection and Advocacy conference has been held to train Protection and Advocacy staff in key issue areas and to ensure that State Directors have the opportunity to exchange information and ideas. To further the coordination of a strong national program, the Administration on Developmental Disabilities has continued a national grant to coordinate technical assistance activities for Protection and Advocacy's Agencies informed on issues and events of importance to them. In addition, the Administration on Developmental Disabilities is in the second year of a project which is currently linking State Protection and Advocacy systems in a telecommunications network which will provide these systems with an ongoing mechanism for sophisticated coordination and information sharing activities.

Question: Has the Department established standards by which the Protection and Advocacy Program can be measured? If so, elaborate on how they were developed and how they will work.

Answer: The Department developed standards by which the Protection and Advocacy program can be measured through a contract with Harold Russell Associates. Under that contract, completed in March 1980, major indicators of Protection and Advocacy performance quality were developed as a result of an extensive field study followed by field tests involving several Protection and Advocacy systems. These performance standards were disseminated to all Protection and Advocacy systems for use in internal evaluations. They will also be of use to the Administration on Developmental Disabilities in designing future program review mechanisms and in developing additional program guidelines. Presently, Harold Russell Associates are developing a quality assurance mechanism which will enable the Administration on Developmental Disabilities to use the performance standards to foster uniform levels of quality in Protection and Advocacy programs and to facilitate comparison of Protection and Advocacy programs.

FEDERAL COUNCIL ON THE AGING

Question: What is the status of the various Federal Council on Aging studies which were mandated by the 1978 amendments to the Older Americans Act?

Answer: The studies mandated by the 1978 amendments to the Older Americans Act are in progress. The approximate dates of completion are March 31 and June 1, 1981.

Question: Which of these mandated studies are being performed by Federal Council or other departmental staff and which are being performed by outside contractors?

Answer: The staff of the Federal Council on the Aging and Assistant Secretary for Planning and Evaluation, HHS, have completed the major proportion of the studies. However, concept papers was received from the various studies from outside contractors- who are experts in the field of aging.

The concept papers were on:

1) Advocacy In Aging - Douglas Nelson
2) Approaches and Obstacles to the Definition of Greatest Economic and Social Need - Neal Cutler
3) Reaching Those in Greatest Need - Jesse F. McClure
4) Age as a Basis for Social Policy - Elizabeth Kutza
5) AOA Program Priorities for Community Services System Development - Anna Freed
6) An Analysis of Purpose and Performance Under Title V of the Older Americans Act - Morgan Management Systems, Inc.
7) A Special Analysis of Low-Income and Minority Elderly Participation Levels in Older Americans Act Programs - Acumenics Research and Technology, Inc.

Also, input was provided by the firm of Jay W. Kim Inc.

Question: What is the funding amount for each of these studies?

Answer: The estimated funding amount for each of the studies/concept papers are as follows: Douglas Nelson - original contract $10,000; Neal Cutler - $15,000; Jesse McClure - $25,000; Elizabeth Kutza - $5,000; Anna Freed - $2,000; Morgan Management (Title V) - $100,000; Acumenics - $75-90,000 and Jay W. Kim, Inc. - $150,000.

Question: What proportion of funds to support these studies is from the Federal Council line item appropriation and what proportion is from other Administration on Aging funds?

Answer: The Federal Council on the Aging appropriations are a line item of the Administration on Aging.

Question: What was the Fiscal 1980 staffing level for the Federal Council, and what is the Fiscal 1981 level?

Answer: There were 10 permanent staff and 2 non-permanent in FY 1980. The staff consisted of three GS-15s, one of which was a Schedule C - Special Assistant to the Chairman, one GS-14, GS-13, two GS-11s, one GS-9, GS-7,GS-5, GS-4, and GS-2 Stay-in-Schooler. For FY 1981, the number of positions remain the same, however, only nine of the positions are currently occupied.

Question: What amount of the Administration on Aging's budget was used to support Federal Council activities during FY 1980 and 1981?

Answer: In FY 1980, the Administration on Aging transferred $500,000 that had been reserved for evaluation purposes to support Phase II of the Federal Council on the Aging mandated study.

DEVELOPMENTAL DISABILITIES PROGRAM

Question: How many staff and what dollar amount could be eliminated from the budget if the Developmental Disabilities program were absorbed under the Department of Education Rehabilitation Program?

Answer: The Developmental Disabilities program has a total of 70 positions and the salaries and expenses budget amount of $2,269,752. If the Developmental Disabilities program is absorbed under the Department of Education Rehabilitation Program, there would be some negotiations of staff and salaries and expenses dollars.

UNIVERSITY AFFILIATED FACILITIES PROGRAM

Question: Do you think the University Affiliated Facilities Program might be more effective and less confusing if a block grant approach were used instead of the present categorical sources of support?

Answer: The University Affiliated Facilities Program is an interagency and interdisciplinary program. It represents a national network of training, services, and research. Funding is obtained from a variety of sources including Maternal and Child Health, Developmental Disabilities, and Rehabilitation Services. It would not be effective in a block grant approach for services to the developmental disabled individual if a specific amount of funds were not provided to address the specific needs of this population. Experience has shown UAF's to be a sound concept and effective mechanism for servicing the needs of developmentally disabled individuals. Prevention, diagnois and treatment of developmentally disabled individuals require special knowledge, skills and a unique type of staff.

DEVELOPMENTAL DISABILITIES PROGRAM - SPECIAL PROJECTS

A recent GAO Report, How Developmental Disabilities Programs are Working, found that the Special Projects Program was not unique or special, and that many of the projects resembled the types of program supported by the State formula grant program.

Question: Why shouldn't we eliminate special projects, consolidating funding under the Developmental Disabilities State Grant program?

Answer: We should not eliminate our special project activities nor should we consolidate the special project allocation under the Developmental Disabilities State grant program. Special project grants have provided developmentally disabled persons with a resource for accessing the service delivery system and for improving the quality of services required to meet their special and generic needs.

STATE AGING PROGRAMS

Question: What Major Activities of the White House Conference on Aging, To Be Held This December, Have Been Completed?

Answer: Technical Committee - 16 technical committees were appointed under the authority of the Conference Law. Each was asked to develop ideas and recommendations for dealing with a specific set of subjects and issues. All but four of these reports are in the final stages of typing and technical committee clearance. The four remaining reports will be ready in a few weeks, probably by April 1st. These reports, when completed, will be available for the consideration of the delegates to be appointed to the National Conference. They also will be available after April 1, 1981, for study by the Congress, the media, national organizations, and the general public.

Mini-Conferences - Under the authority of the Conference, 40 groups of organizations or single organizations were given an opportunity early in the Conference process to conduct a special mini-conference to develop ideas and recommendations for the consideration of the delegates. In particular, this process enabled the major racial and ethnic groups to examine from the standpoint of their special concerns the issues involved in the development of a substantially larger older population. Also, the mini-conference process was used to permit a wide variety of subjects to be considered more intensively that might be possible through the crowded agendas of the 16 technical committees. Altogether, 40 mini-conferences have been authorized, of which 39 are completed and one will be held in the first week of March 1981. The summaries from these conferences will be given to the Conference delegates for their consideration, and the sponsoring organizations are authorized to give them wide circulation, at their own expense. A further value of the mini-conference process has been that it enabled a broad range of organizations and individuals to participate in a conference process and help shape reactions to the issues as well as recommendations for consideration of the delegates.

State and Territorial Conferences - 58 State and Territorial Conferences are being held in connection with the 1981 White House Conference on Aging. The first of these State Conferences was held in Florida in September 1980. The last Conference will be held in Minnesota in early June 1981. The recommendations from these Conferences in summary form will be presented to the delegates at the 1981 Conference. We also have asked the states to include within their summaries the results of thousands of grassroot forums held in their cities and towns. Some of the State Conference reports have become available, the rest will be available in early summer of 1981.

National Meeting - With respect to the National Meeting, detailed plans have been undertaken to support a Conference of 2,000 delegates and 2,000 observers. The Conference dates are

November 30 - December 3, 1981. The meetings will take place in the Hilton and Sheraton Hotels, in Washington, D. C.

Delegates and Observers - The Conference has completed a substantial portion of the delegate selection process and a portion of the observer process.

Of the 2,000 delegate position, 1,000 were allocated to the governors in quotas based on population, 539 were allocated to the Congress on the basis one delegate per member. The Secretary of Health and Human Services will devise a plan for the allocation of the remaining several hundred positions. These are expected to be allocated to various national and other organizations. The process of delegate selection is to be completed by the end of June 1981.

Question: What is the estimated amount of funds expended on Conference activities to date?

Answer: The estimated amount of funds expended on Conference activities is $2,166,000.

Question: What is the estimated unexpended balance of funds from the 1979 appropriation?

Answer: From the FY 1979 appropriation, we have left a balance of $834,000. Since the Conference's inception, the Congress specified that the Conference funds should be "no year money"; therefore, unexpended balances have been carried over to each of the next two fiscal years. This understanding also made it possible for the Conference to avoid asking for news funds in FY 1980.

Question: What is the current number of Conference staff?

Answer: The Conference was authorized to hire and has hired 36 people on appointments that last one year or more. It also has hired 13 people under appointments that last less than a year. In addition, 18 staff members have been detailed from federal agencies that have programs in the field of aging. Two more people, serve under Intergovernmental Personnel Act Agreements, and several interns are working for varying periods of time.

For advice on Conference content and issue development the Conference has an Advisory Committee of 55 members, appointed by the Secretary. Also, appointed by the Secretary are 135 people who serve on 16 Technical Committees, each of which is developing an issue area for the Conference. In order to save funds, approximately 50 of the Advisory Committee members agreed to serve on the Technical Committees as well, and are included in the total of 135. The 16 Technical Committees are supported by approximately 20 consultants who provide expertise in many special issue areas.

In February 1981, when the Technical Committee phase was completed, a planned staff reduction was put into effect. This reduction, which was necessary to keep within the overall expenditure plan included termination of the appointments of most of the consultants and experts who had been working for the 16 Technical Committees. At the time of the National Conference, some staff build-up will be necessary, but most of the additional help will be needed for only 2 weeks to a month and will be borrowed from other agencies and national organizations, with little or no cost to the Conference office.

Question: What number of staff are you proposing to carry out the follow-up activities of the Conference in 1982?

Answer: Under the Conference Law, the Secretary of Health and Human Services, is given the authority to plan and conduct all phases of the Conference, including the follow-up phase. Accordingly, the decision on the size and nature of the staff for this later phase will be a decision made by the Secretary. During this period, several specific activities will be under way. The first, essentially, is an archival one, namely a narrative account of the Conference along with the official records of all its aspects. The Secretary also is charged with developing a comprehensive coherent national policy on the aging, as a part of the Conference report. He must do this within six months after the end of the National Meeting, or by June 3, 1982. Within 90 days thereafter, the law requires that he submit a plan to implement the report, including draft legislation, Executive Orders, or other means of action. The Secretary, of course, may draw on a variety of resources and mechanisms for accomplishing these purposes. These might include the Conference staff and its resources made available from other parts of the government and the private sector.

ADMINISTRATION ON DEVELOPMENTAL DISABILITIES

Question: What would be the impact of merging the Developmentally Disabled State Grants program with the Vocational Rehabilitation State grants program, under the Department of Education?

Answer: Although the vocational rehabilitation program and the developmental disability program may seem, at first glance, to be similar, actually their mission and clientele are very different. Whereas the chief criterion for service eligibility for vocational rehabilitation is a determination that the client will be ultimately employable, a disabled person's eligibility for services under the developmental disabilities program is that he/she is essentially too severely handicapped to be employable. Further, vocational rehabilitation services are generally designed to be limited in duration, while developmental disabilities services are expected to be of long duration, if not lifetime. Additionally, the 800 or 900 million dollars expended by the Rehabilitation Services Administration on a matching formula grant to the States is for the purpose of purchasing direct services to clients. The $43 million dollars contributed by the Federal developmental disabilities program on a matching basis is for the purpose of subsidizing a planning and coordinating mechanism in each State to bring together $4 billion of programs and services funded by nine Federal agencies. Developmental Disabilities funds are intended to support the planning and coordinating activities in each State to focus a variety of federally funded services on severely handicapped persons. While the vocational rehabilitation program claims a total of more than 1 million clients in its service "pipeline" each year, while rehabilitating upwards of 250,000 annually, the developmental disabilities program estimates its annual service caseload at about 250,000 who require a variety of long term services. The number of potential eligibles in the vocational rehabilitation target group is about 20 million handicapped persons, while the developmental disabilities client group under the new definition is about 3.5 million.

The conclusion to be drawn from these facts is that merging the Developmental Disabilities State Grants program into the Vocational Rehabilitation State Grants, will undoubtedly have the effect of diminishing the Developmental Disabilities program ability to target services onto its special client population. Since the vocational rehabilitation program does not have the structure nor mandate to plan, coordinate, and advocate on a Statewide basis for severely disabled people, it is likely that this essential activity would erode under vocational rehabilitation auspices.

The uniqueness of the developmental disabilities program is the reason for its existence: no other Federally supported program has as its purpose, the bringing together of a variety of Federally funded programs to serve the needs of severely disabled persons.

Finally, developmental disabilities activities are operated through State human resource agencies, and not through State Departments of Education, which are the working partners of the Federal Department of Education. Therefore, having this program administered by the Department of Education would disrupt the existing well-established working relationship between Federal and State agencies.

EVALUATION OF DEVELOPMENTAL DISABILITIES PROGRAM

A comprehensive evaluation system for the Developmental Disabilties Program is required to be in place in the States by October 1, 1982. Some States have apparently expressed alarm at the projected cost of the evaluation system.

Question: What is your best estimate of the cost of the developmental disabilities evaluation system?

Answer: Review of cost estimates submitted to the Administration on Developmental Disabilities by the States reflect a broad range in design and implementation costs. These costs ranged from a low of approximately $24,000 to a high of over a million dollars. However, only five States estimated their design and implementation cost at levels exceeding $100,000 per year for the two years of development activity.

Since these estimates were largely prospective rather than retrospective, they may not be totally accurate, and should be considered low. Since most States had not begun implementation, certain factors may have been overlooked in deriving their cost estimates.

However, based on those estimates and estimates establish independently by the Administration, it is anticipated that the costs for design and implementation of the evaluation system will amount the approximately $6,250,000 per year for the two development years. However, because of the Administration commitment to memorize reporting requirements, States may have estimated the resources which would be needed to report to Federal information requirements. As a result, even the $6.25 million estimate may be high.

Operating cost after the systems are in place in 1982 should be somewhat lower. Although States estimates for operating cost varied more than their development costs, it can be estimated that yearly operating costs will amount to between $5 and $5.5 million.

Question: Do you think the cost of evaluation is exessive in view of the fact that Developmental Disabilities State grants are only $50 million.

Answer: In responding to this question, it is necessary to establish a distinction between evaluation and the evaluation system mandated in Section 110 of P.L. 95-602. Evaluation is an important if not essential part of the delivery of services. However, there are many ways of evaluating service delivery, such as through standards and quality assurance mechanisms, through administration and/or peer review processes, and similar types of traditional evaluation procedures. Traditionally, program evaluation has been conducted using those types of approaches.

The evaluation system required under Section 110 of P.L. 95-602 represents a relatively recently conceived approach to evaluation. In fact, as evidenced by the fact that only a handful of States had just begun to undertake the development of such client-centered systems, the Section 110 system approaches the State-of-the-art in service program evaluation.

Most States already have in place one form or another of more traditional evaluation procedures. Thus, had Section 110 been predicated on those approaches, cost would have been negligible. However, it would not have contributed (as it does) to the resolution of the most important evaluation questions.

- what benefits do disabled persons derive from the receipt of services in terms of improved functional capabilities?

- what services are most effective in improving the functional capabilities and/or developmental status of developmentally disabled persons.

- what is the relationship between traditionally derived evaluation results and client developmental progress.

These issues transcend the Developmental Disabilities Program to apply to virtually any service program designed to assist dependent and/or vulnerable populations (e.g., the poor, elderly persons, other disabled persons). Consequently, the investment to establish and implement the Section 110 evaluation system, in comparison to the benefits to be derived from its contribution to answering these essential problems is minor and irrelevent to the size of the Developmental Disabilities State grants. Use of the State Grant program as the laboratory for testing these issues, especially in light of the diversity of programs supported through State formula grant funds represents a cost-effective approach to grappling with problems of broad applicability.

Finally, approximately two-thirds of the States estimated that costs for designing and implementing their evaluation systems in accordance with the Section 110 mandate amount to 10% or less of their basic formula grant allocation. This does not represent an excessive proportion of their resources considering that the evalution system constitutes an entirely new dimension and component of State administration activity.

In summary, insofar as the Developmental Disabilities evaluation system as required in Section 110 of P.L. 95-602 will result in a significant advancement in the State-of-the-art in human services education and decision-making capabilities, it in itself should be considered a worthy investment. In addition, costs associated with developing these systems represent a relatively small proportion of State formula grant funds and cannot be considered excessive according to State estimates.

DEVELOPMENTAL DISABILITIES-CONTRACTS

Question: In responding to the recommendations in the February 20, 1980 GAO report concerning the State Formula Grant Program, how frequently has the Department resorted to contracts?

Answer: The Department has not resorted to contracts in responding to recommendations in the February 20, 1980 GAO report concerning the State Formula Grant Program. However, The Department has resorted to contracts in meeting evaluation needs and the mandates of P.L. 94-103 and P.L. 95-602. Prior to P.L. 95-602, the Department awarded a contract (October 1977) to develop Program Performance Standards for State Planning Councils and Administering Agencies. A contract was also used to design the specifications for the evaluation system mandated in P.L. 94-103. Contracts were used to develop the Program Administrative Review system in 1978 and for technical assistance to States in developing plans to implement the Comprehensive Evaluation System mandated in P.L. 95-602 Section 110.

In response to the GAO recommendations to establish appropriate grant review mechanisms in the States, ADD Staff have provided technical assistance to the States in grant review processes related to sub-grants for services awarded from the formula grant monies. Formal requirements are contained in the pending final regulations for the Developmental Disabilities Program. ADD staff, both regional and central office, conduct the Program Administrative reviews.

As can be seen, the contracts used to meet the legislative mandates for performance standards and evaluation systems only cover the development of the tools and technical assistance in the field testing of the instrument in certain States. In sub-section (d) of Section 110 of (P.L. 94-103) Congress specifically stated that the Secretary may use grants or contracts to public and private non-profit entities to assist in developing the evaluation system to be developed under sub-section (a).

Question: What has been the cost of these contracts?

Answer: As previously mentioned there have been no contracts awarded in response to the GAO report recommendations. The cost of contracts awarded to meet the evaluation and legislative needs related to the State Formula Grant Program are:

1978	$ 248,300
1979	$ 115,402
1980	$ 300,000

Question: Why can't the Department administer this program without the use of contracts?

Answer: Contracts have not been used to administer this program. The purpose of using contracts has been to develop tools to enhance the Department's own administrative capabilities. The development of uniform quality assurance and accountability systems that are fair and are not federally biased is important. Evaluation efforts must be viewed as objective by those who are responsible for collecting data as well as those who have the charge of interpreting instrument measures and results.

The development of these tools and measures has been repeatedly identified as necessary for the program to function effectively by both Congress and the GAO.

The high level of methodological sophistication needed to develop these instruments such as the Program Administrative Review and the Comprehensive Evaluation System does not exist in the present staff nor is it needed on an ongoing basis. Program staff responsible for implementation of congressional mandates need the tools necessary to carry out the intent of Congress. Short term efforts that involve highly specialized skills do not require permanent positions or the expenses associated with maintaining staff where there is not an ongoing need. In addition, instruments and evaluations developed independently have been more widely accepted by States when they are perceived as not including federal bias. We also must remember that the Administration on Developmental Disabilities' use of contracts for technical assistance is not to provide technical assistance on the Developmental Disabilities program but rather on the instruments or tools and their use in the States.

UNIVERSITY AFFILIATED FACILITIES

The February, 1980 GAO report, "How Federal Development Disabilities Programs are Working," found that the University Affiliated Facilities programs lack a clear, consistent focus. This may be due in part to the differing expectations of the various Federal funding sources.

Question: Specifically, what has been accomplished with the money provided for University Affiliated Facilities under the Developmental Disabilities Program?

Answer: The University Affiliated Facilities provide three specific types of services: (1) direct client services. (2) training, and (3) research.

The services provided by the UAF's are grouped in eleven categories: general support, identification, treatment, education, counseling services, family support, living arrangements, vocational services, recreation, transportation, and indirect services.

Listed below are some of the specific accomplishments of the UAF Program.

- 24,000 developmentally disabled individuals were provided direct services such as evaluation, treatment and residential care.

- 14,000 college students received instruction in developmental disabilities in 36 UAF's. 350 professionals majored in programs for the developmentally disabled.

- 100,000 non-university individuals participated in training activities. Fifty-five percent of these trainees were professionals and seventeen percent paraprofessionals employed in jobs serving the developmentally disabled population. Six percent of these trainees were parents of developmentally disabled individuals.

- The UAF's provided assistance in planning and training to State Councils, Protection and Advocacy Systems, State agencies and local service agencies confronted with complex problems.

- Funds under the Developmental Disabilities program have been actively used to create and support applied research programs for the improvement of service delivery and training in such areas as physical habilitation, genetics, early intervention and evaluation.

UNIVERSITY AFFILIATED FACILITIES - USE OF CONTRACTORS

Question: What are the results of the contract with independent surveyors to survey University Affiliated Facilities for compliance with the standards established by an earlier contract?

Answer: The Department has not contracted with independent surveyors to establish compliance with the standards. It plans to utilize ADD regional and central office staff to survey for compliance with the standards.

Question: Why didn't the Department develop the performance standards and survey for compliance with them inhouse rather than use contractors?

Answer: The Department utilized the services of a contractor in the development of the standards to assure consensus and objectivity in their development. However, the finalized standards incorporated the contractor proposed standards with standards suggested by other sources, including Departmental staff. As mentioned previously, compliance with the standards will be determined by Departmental staff.

Question: Does the Department plan to continue to administer much of this program through contractors?

Answer: No. The Department plans to utilize its staff to administer this program, including the surveying for compliance with the standards.

ADMINISTRATIVE COSTS OF STATE AGING AGENCIES

Question: What has been the effect of the requirement, enacted into law in 1978, that each State Agency on Aging expend no more than 8.5 percent of its Federal Allotment for Social and Nutrition Services to support Administrative costs of local Area Agencies?

Answer: Prior to the 1978 amendments to the Older Americans Act, 15% of the funds awarded for Area Planning and Social Services could be used for the administration of area plans. The 1978 amendments allow for up to 8.5% of the funds awarded for Social Services and Nutrition Services to be used for this purpose. Even though the percent of funds which can be used for the administration of area plans is lower, because the total amount of funds from which this maximum can be computed has been increased (by the inclusion of Nutrition funds), the net result has been that States have had a higher dollar level available to use for this purpose.

An estimated 5.5% ($25 million) of the funds alloted in FY 1979 under Title III parts B and C were used for the administration of area plans. In FY 1981, an estimated 6.2% will be used for this purpose.

Question: Have any States set the 8.5 percent Federal limitation at a lower level? If so, what level?

Answer: As stated earlier, on a national level, only 6% of the funds available are being used for area plan administration. Thirty-six states use less than 8.5% of their funds for this purpose. (In addition, in FY 1980, 13 States were designated as single planning and service area states, and were not using Social Services or Nutrition Services funds for the administration of area plans.) Fourteen States use less than 6% of their funds for these activities.

INCREASED STATE MATCHING

Question: Beginning in 1981, the Older Americans Act requires non-Federal matching for Social Services, Senior Centers, and Nutrition Centers to increase from 10 percent to 15 percent. Is there evidence that State Agencies will be able to meet the increased matching requirement imposed on Social and Nutrition Services in 1981?

Answer: Compliance with the requirement that the non-federal share represent at least 15% of the funds available for the various services is only measured when a State submits a final report for a particular fiscal year. Therefore, we are not able to determine how many States are or are not meeting this requirement in FY 1981.

Further, the Older Americans Act states that funds to meet the additional 5% share must be provided by State resources. Data available from financial reports does not specify funds provided from State sources, therefore we are not able to evaluate compliance with this aspect of the requirement. Compliance will be determined through audits.

Data for the second quarter of FY 1980 does indicate that 60% of the States were matching the FY 1979 Social Services funds at 15% or more and that 46% of the States were matching funds alloted for Nutrition Services in FY 1979 at 15% or more. We have no indication that States will have difficulties in meeting this requirement.

Question: If so, what is the average level of non-Federal match which States/Area Agencies have been able to generate above the required level?

Answer: Since some final reports for FY 1980 have yet to be submitted, we are unable to determine the average match per State. The data cited before, does indicate that in the 34 States meeting or exceeding the match requirements for Social Services, non-federal funds represented from 15 to 33% of the funds available. Non-federal funds used for Nutrition Services represented from 15 to 42% of the funds available in the 26 States meeting or exceeding the 15% requirement.

USE OF CONTRIBUTIONS FROM ELDERLY

Question: What steps is the Administration on Aging taking to assure that program income generated from contributions by older persons for Social and Nutrition Services is being used to increase the number of these services?

Answer: Use of program income to increase social and nutrition services is measured both by audits of area agencies and by State assessments being conducted by the Administraton on Aging regional offices. As part of these assessments, States are being evaluated on the extent to which they monitor area agency use of program income to increase services.

Question: Why shouldn't payments be required, instead of voluntary, from those who can afford it?

Answer: The objectives of the Title III program speak to maintenance of independence and dignity for older individuals; removal of individual and social barriers to independence; and provision of a continuum of care for the vulnerable elderly. The services to be generated and or supported by the program are not seen as supplementing income. The Act also emphasizes services to the economically needy elderly. Further, upon review of the Conference Report accompanying the 1978 amendments to the Act, we concluded that the Congressional intent was to provide older persons with an opportunity to contribute only to the extent that their resources allow.

We have considered making contributions for services received mandatory, but decided against it because of the emphasis provided in the legislation. We did not want to preclude participation because of inability to pay thereby not serving the neediest older people. Further, the risk of embarassing recipients of services who could not contribute to services and thus feel that they should not receive the services also contributed to our decision. The benefits derived by a person receiving nutrition services, which not only provide for a nutritious meal, but perhaps more importantly, counteract the effects of social isolation faced by persons living alone, far outweigh the benefits derived from a contribution. We also considered that the costs of administering a means test to differentiate ability to pay would be substantial and burdensome.

At the present time, almost two-thirds of the participants are estimated to be low-income older persons. We do not have information about the average contribution per person, nor the income status of persons who contribute. Evaluation studies do indicate that low-income participants do not object to voluntarily contributing towards the cost of the meal, but do object to pressure being placed on them to contribute. Mandatory fees would make it increasingly difficult for programs to fulfill the statutory requirement that priority be given to older persons who are the most socially and economically needy.

Contributions are solicited from participants of both Nutrition and social services. In FY 1980, program income outlays, which are mainly composed of contributions made by participants, totaled $57 million.

Question: In this time of severe budgetary restraint, why should elderly persons who are not poor be allowed to get free meals and Social Services--especially when other low-income elderly are going unserved?

Answer: As stated before, we did consider making contributions for services mandatory, but decided against it. Let me emphasize that even though we are opposed to mandatory contributions, we are making efforts to insure that those that can contribute do so. The regulations published following the 1978 amendments to the Older Americans Act specifically mandate service providers to provide a fair and voluntary opportunity to contribute to the cost of services and to protect the privacy of older persons with respect to contributions made. Service providers must give adequate publicity to the method through which contributions can be made. Advisory Councils are encouraged to recommend contributions for each service.

There is some evidence that these efforts are resulting in increased program income. In FY 1978 per meal program income outlays, which include contributions made by participants, averaged $0.19 per meal, in FY 1980 they averaged $0.32 per meal.

FUNDS USED FOR PRIORITY SERVICES

Question: What proportion of Area Agencies are meeting the requirement to expend some funds on priority services--that is access, in-home, and legal services for each of the three service categories?

Answer: Ninety-three percent of the area agencies are meeting the requirement that some funds be used for each of the priority services -- access, in-home, and legal services. The other 7% received waivers from this requirement as follows: 22 received waivers from legal services requirements, 17 received waivers from in-home services requirements, and 5 received waivers from access services requirements.

Some problems have been identified in area agencies in three States. These problems are being resolved through technical assistance provided by the State and by our regional offices.

Question: How many State Agencies on Aging have granted Area Agencies waivers of this requirement?

Answer: For FY 1981, 13 States granted waivers to one or more area agencies from the requirement that funds be expended in each of the priority areas. These waivers only exempted the area agency from expending funds for one of the three priority services. Waivers were granted to those area agencies where adequate services were being provided from other sources.

Question: Is there evidence that services have increased in these priority services categories?

Answer: Program performance reports submitted by State agencies reflect an increase in the units of service provided in each one of the priority services. The data is summarized below:

(Person units of service)	FY 1979	FY 1980	Increase
Access			
Transportation	2,219,000	2,259,000	+40,000
Outreach	1,575,000	1,743,000	+168,000
Information and Referral	2,597,000	5,028,000	+2,431,000
Legal	300,000	416,900	+116,800
In-home	678,000	700,000	+22,000

Question: What guidance has the Administration on Aging given to State Agencies as to the most efficient manner of providing these services?

Answer: The Administration on Aging regularly provides technical assistance to State Agencies on Aging on program improvements as part of its ongoing commitment to improve the efficiency and effectiveness of services. State Agencies replicate this assistance to Area Agencies. Assistance handbooks were developed and distributed on the following services: information and referral, legal, transportation, and on senior centers. Many of these tools are in use by Area Agencies. The nutrition handbooks developed earlier, are now being updated. In addition to these major service guides for planners and program operators, program guidance is provided through periodic program instructions and through direct technical assistance from the regional offices and from grantees and contractors funded to service the network.

Further, training and technical assistance grants are made directly to State agencies to use for locally determined training needs, many in the area of priority services. The program provides for both direct training and for the development of curriculum and instructional materials needed to upgrade the capacity of the network personnel.

Our Office of Research, Development and Evaluation is currently synthesizing research and demonstration findings in areas such as community care systems and will prepare "best practice" guides for State and local agency use. These findings assist in the improvement of service delivery.

VULNERABLE ELDERLY

Question: To what extent are Administration on Aging programs serving the particularly vulnerable elderly---who may be described as low income, minority, disabled, socially isolated, or among the very old?

Answer: The Administration on Aging does not collect data on all persons who may be described as vulnerable elderly and the extent to which Title III Programs are serving these individuals.

We do collect data from the States that reflects that in 1980 the low income and minority elderly participated in these programs as follows:

	Social Services	Nutrition Services
% of participants who have low incomes (as defined by the Bureau of the Census	53	63
% of participants who are minorities	21	19

In addition, the Long-term Care Ombudsman Program funded under Title III-B investigates complaints by residents of long-term care facilities who are vulnerable elderly persons. Under Title III programs, an estimated $32 million is provided for in-home care, and 23 million meals are delivered to the home to vulnerable elderly persons.

Finally, through the long-term care initiative, a major activity of the Administration on Aging, direct services are provided to the vulnerable elderly. This initiative includes the Long-term Care Gerontology Centers; our joint effort with the Health Services Administration (dealing with expanded primary health care for elderly at public health hospitals, and health centers in urban and rural areas and on Indian reservations); model and research projects which address the particular services needs of the vulnerable elderly and ways to provide these services; and the Channelling demonstrations.

The Administration on Aging has always encouraged, in the strongest terms, that those individuals in greatest need receive priority in services under the Older Americans Act. We will continue to do so with all the tools at our disposal. One of the tools used currently has been an initiative in the Nutrition Programs which tracks progress concerning services to the vulnerable elderly.

Question: How can Older Americans Act resources be coordinated with other resources to provide improved service to the vulnerable elderly?

Answer: The Administration on Aging is currently involved in several activities which are aimed at the coordination of resources to provide improved services to the vulnerable elderly. Some of these are:

- o A joint effort by the Administration on Aging and the Farmers' Home Administration which seeks to demonstrate means of improving coordination between the aging and Farmers' Home networks. Projects demonstrate collaboration in planning for and operating congregate housing and social service projects through out rural America.

- o Demonstrations to increase the amount, scope, and quality of health and social services to older persons by coordinating the existing social and health service systems operated under the auspices of the Administration on Aging and the Health Services Administration.

- o The geographically dispersed Long-term Care Gerontology Centers seek to develop a multidisciplinary academic program comprised of: teaching and training; basic and applied research and evaluation; model service and community laboratories; and a program of technical assistance and continuing professional education. The community laboratories and the technical assistance/continuing education component are directed to upgrading skills of multidisciplinary teams of professional and practioner personnel employed in hospitals, institutions, and community agencies serving functionally disabled (mentally and physically impaired) older people.

Question: What direction has the Administration on Aging given to States in efforts to improve service to vulnerable, low income, and minority older persons, and what actions have States taken in this regard?

Answer: The Administration on Aging has been involved in a number of activities designed to provide guidance to States in their efforts to improve service to vulnerable low-income and minority older persons. On March 31, 1980, AoA published regulations governing grants for State and Community Programs on Aging to implement the 1978 Comprehensive Amendments giving priority to serving those of greatest economic or social need. To ensure that funds are distributed within a State in a manner that is most likely to meet this targeted service delivery approach, the AoA regulations require the intra-State funding formula to reflect the proportion of those with greatest "economic or social needs." This requirement, given the definition of greatest economic and social need, enhances the services delivery opportunities for disadvantaged minorities as well. In addition,State plan guidance has referred to targeting services for low-income and disadvantaged minorities. State Agency Assessments also refer to effectiveness in targeting services to those in greatest social and economic need (--i.e. the vulnerable, low-income and/or disadvantaged minority older person.)

In addition, Policy Issuances to the network have stressed the need for specific planning and action steps to give maximum consideration to the needs of low-income and disadvantaged minority older persons. A Program Instruction to State Agencies addressed the subject of improving services for low-income and minority older persons. Specifically, the Administration on Aging developed targets to increase participation of low-income and disadvantaged minority older persons in the nutrition programs. Most States established appropriate targets in FY 1979 based on various factors and circumstances in the States. Nationwide, States have met and exceeded those targets in every case.

In 1980, general guidance was sent to State Agencies advocating the need to reach low-income socially disadvantaged, minority participants through the nutrition program. In relation to this 1980 guidance, States submitted plans which were aggregated into Regional Plans that again emphasized the need to plan for and to serve the vulnerable, low-income and minority. In 1981 AoA submitted guidance to States that would enable them to more accurately identify the low-income, disadvantaged minority elderly in their population.

AoA has also funded specific research and demonstration projects which address issues pertinent to low-income and minority elderly. It is anticipated the results of these will provide additional "how to" guidance and expertise to States and sub-state units on aging in implementing further targeting techniques (especially through outreach, and information and referral efforts.)

COORDINATION OF SERVICES FOR THE ELDERLY

Question: One of the purposes of the Older Americans Act is for local Area Agencies on Aging to coordinate the services of other Federal, State, and local service providers and direct these services to the elderly. What has the Administration on Aging done to determine the extent to which Area Agencies are effectively coordinating services at the local level?

Answer : An assessment of State and Area Agencies being conducted by the Administration on Aging's Regional Offices, is examining among other things, procedures established to coordinate services of other Federal, State and local services providers. These assessments will provide information about activities currently in place and point out areas in which the agencies need technical assistance to improve their efforts.

SERVICES TO POPULATION OVER AGE 75

Question: The Older Americans Act specifically required that preference under the program be given to those with the greatest economic or social needs. In view of the prospects for growth of the older population in the coming decades, especially those over 75 years of age, and given the limited resources for social service programs, what steps has the Administration on Aging taken to improve services to these groups of elderly?

Answer: A number of the activities administered by this program have impact on those older persons 75 years of age or older. These persons are more likely than the younger older person to be among the vulnerable elderly and to need services in the home.

In particular Title III funds support in-home services, including home-delivered meals, the services of a long-term care ombudsman to monitor facilities such as nursing homes, services to residents of long-term care facilities, day care services, needs assessments and case management.

An initiative on knowledge and capacity building to improve care and services for functionally impaired older persons will also impact persons 75 years and older. As part of this initiative, the Administration on Aging is funding the Long-term Care Gerontology Centers which support projects for the development of comprehensive, coordinated systems of long-term care; and place special emphasis on activities designed to improve access to long-term care services through assessing needs, developing plans for care, making referrals and improving the quality of services in both non-institutional and institutional settings. The Administration on Aging also supports model projects and research which seek improvements in services to the vulnerable elderly.

AGING

Question: What measurable benefits have occured since the consolidation of the Nutrition Program, the Center Program, and the Social Services Program?

Answer: The 1978 Amendments to the Older Americans Act allowed State Agencies on Aging a two-year period in which to complete the consolidation of programs required by the amendments. The Act allowed for the Commissioner on Aging to provide the States, upon request, waivers from 13 mandates in the legislation. In FY 1979, and to a lesser extent in FY 1980, most States requested waivers from one or more of the mandates.

FY 1981 has been the first year in which all mandates of the 1978 Amendments have been in effect, thus it has not been possible with this limited experience to measure the benefits derived from the consolidation of the programs. However,there are indications that the consolidation occurred with the minimum disruption, and the potential exists for considerable improved services to older persons as a result of the consolidation.

Question: How does AoA assure itself that the target population is being served, and how does AoA determine whether or not 50 percent of the Social Services funds are being spent for the priority services noted in Section 306(A)(2) of the Act?

Answer: Determination of use of at least 50% of the funds available to an area agency for the three priority services -- access services, in-home services, and legal services, is made through audits and is also monitored by State Agencies and the Administration on Aging through quarterly financial reports submitted by the area agencies. Summaries of these reports for the third quarter of FY 1980 reflect that, of the funds allotted in FY 1980, 55% were being used for the priority services.

The Older Americans Act mandates that in providing services under Title III, priority be given to individuals with the greatest social and/or economic need. Data collected through Quarterly Program Performance reports submitted by the States reflects that 53% of the recipients of social services, and 63% of the recipients of Nutrition Services in FY 1980 were low-income elderly persons.

Prior to the 1978 Amendments to the Older Americans Act, emphasis was provided on services to minority elderly versus the socially needy elderly. Data on socially needy older persons receiving services was collected for the first time in the first quarter of 1981. Several States have yet to complete these first quarter reports, therefore a national summary is not available at this time.

HOME-DELIVERED MEALS

Question: To what extent does the Home-delivered Meals Program inhibit elderly persons, who could get to Senior Centers for the regular "Congregate" Meals Program, from making the effort to get out of their homes?

Answer: The Services Delivery Assessment conducted by the Office of the Inspector General in the Department of Health and Human Services indicates that some recipients of Home-delivered Nutrition Services may be persons who could more properly be served in a congregate setting. The results of this assessment are being made known to the State Agencies on Aging, and corrective action mandated.

The Home-delivered Nutrition Services Program should not inhibit elderly persons from attending Congregate Meals Programs. There is flexibility provided to the States in the portion of funds that are available for each congregate and home-delivered meals so that each State can adjust funding to meet its particular needs. The Older Americans Act allows for States to request transfers between the allotments received for Congregate and Home-delivered Nutrition Services with the approval of the Commissioner on Aging. The regulations published pursuant to the 1978 amendments to the Act allowed States to transfer up to 15% of the funds between the two allotments on their own authority, and to request of the Commissioner permission to transfer funds in excess of the 15%.

Question: What actions have been taken to ensure that only those worst in need of home-delivered meals---the truly home-bound elderly--- are receiving services?

Answer: As mentioned above, we know that there are some problems with the delivery of meals to persons who are able to attend congregate nutrition programs. We are in the process of instituting corrective action to minimize the problem.

Every nutrition project has a waiting list of persons who need but are not receiving services. The budgetary constraints alone, should provide an incentive for projects to take every action necessary to insure that only those persons needing services receive them.

Further, an assessment of each applicant's need for a home-delivered meal by the agency is required in the regulations.

TRANSPORTATION FOR THE ELDERLY

Question: Now that the previously separate Nutrition and Social Services Programs have been consolidated, has it been easier to get transportation for the elderly to get to Senior Centers for the Hot Meals Program?

Answer: Some problems with providing transportation services to congregate nutrition sites exist, particularly in regard to the increased costs. The 1978 amendments to the Older Americans Act disallow the use of Nutrition funds after September 30, 1980 for transportation and other social services associated with Nutrition Services. States will have to adjust their Title III-B program priorities in order to continue to provide these services.

Question: How are States and area agencies working with Transportation Service Providers to assure there is no duplication of service?

Answer: A recent report on "Improving Transportation Services for Older Americans" (September 1980), prepared by the Institute of Public Administration and Eco-Sometrics Incorporated indicates that State and Area Agencies are working with transportation service providers to assure there is no duplication of service. However, the study does point out that a wide range of statutory, funding and perceptual barriers still exist and recommends future activities, directions, legislative and policy changes needed to facilitate optimal coordination of resources and services.

Survey responses indicated that a number of the area agencies have attempted to mandate coordination by making their transportation grants conditional on participation in coordinating councils. These coordinating councils have been helpful and the Administration on Aging is encouraging State Units on Aging to assist area agencies in using this approach.

The Transportation Study also shows how area agency efforts to develop common reporting forms, uniform systems of cost accounts, common service definitions and other uniform administrative procedures to facilitate coordination can be helpful.

More than five years ago, the Administration on Aging initiated efforts to foster increased coordination through inter-agency agreements. In June of 1975,the Administration on Aging and the Department of Transportation signed a joint agreement initiating Federal level efforts to encourage State and local transportation coordination. In November of 1975 the Institute of Pubic Administration and the Administration on Aging published a planning handbook which was reprinted by the Department of Transportation. The two agencies then sponsored three regional workshops. In January of 1979 a Site Assistance Kit was completed and in the spring of 1979 training sessions were held in using the kit.

The Administration on Aging has also tried to remove administrative barriers to facilitate State and local transportation coordination and has provided the network of State and Area Agencies with technical assistance for this purpose. An example of this type of directive was a May 30, 1980 communication to Regional Program Directors requesting them to designate a representative to work with the Regional Office lead official on transportation activities. The memorandum transmitted materials to facilitate coordination with the Rural and Small Urban Transit Program and also identified other Federal funds that could be used for this program's local share. Other coordination efforts involved activity such as removing insurance barriers for volunteer transportation providers. The Administration on Aging is now planning additional efforts to encourage and facilitate increased coordination of transportation resources and activities.

EVALUATION STUDIES OF ELDERLY

Question: How are funds available under the Older Americans Act for program evaluation being utilized?

Answer: Section 207(g) of the Older Americans Act allows the Secretary to use the greater of 1% of the funds appropriated or $1,000,000 for evaluation activities. Funds available for evaluations are used by the Administration on Aging, the Federal Council on Aging and the Office of the Assistant Secretary for Planning and Evaluation to sponsor evaluations of programs affecting the elderly. Title III funds available for, but not used for evaluation activities are realloted to States at the end of each fiscal year.

Use of funds available for evaluations has been limited in recent years by Congressional ceilings on the amounts the Department may spend on consultant services and by other administrative limitations.

Question: What program evaluation studies have been conducted on the Administration on Aging's program during the past three fiscal years?

Answer: The following evaluation studies were funded in fiscal years 1978, 1979, and 1980:

FY 1978 Evaluations

- The Evaluation of the Implementation of Title XX (Jointly funded with the Administration for Public Services) - This two-year study examined the nature, objectives, and results of State and Area Agency on Aging participation in Title XX. State and Area Agency's activities related to Title XX were found to include negotiation of cooperative agreements, participation in title XX advisory councils, exchange of planing and needs assessment data, review and comment on Comprehensive Annual Service Plans, attendance at public hearings, and negotiation of purchase of service agreements. The study evaluated these activities and showed that State and Area Agency activity positively correlates with results. Major findings indicate that non-monetary concerns such as service mix, outcomes, and program policy may be even more important than the "fair share" issue.

- The Evaluation of "Over Easy" - This study examined the audience reaction to "Over Easy" which was America's first daily television series for older persons. The series which originated with support from the Administration on Aging (and is now sponsored from other sources) was being broadcast in prime time hours Monday through Friday by most local Public Broadcasting System stations. "Over Easy" was designed to foster positive attitudes about aging in society and among older persons themselves. The program addressed a wide range of concerns of older persons.

FY 1979 Evaluations

- Longitudinal Evaluation of the Nutrition Program for the Elderly - The first phase of this on-going evaluation study examined 91 sites and concluded that nutrition projects are placing substantial emphasis on serving the low-income elderly. The study found that participants are more likely than non-participants to live alone and be members of religious and social groups. The study also concludes that the great majority of participants are satisfied with the meals and in general, participants eat better than do non-participants. The study describes the program characteristics,variations of its local implementation, and assesses program impacts on participants. The second phase will measure changes in impact variables over time and will increase the sample size to account for the two fold increase in nutrition sites and the addition of the home-delivered meals component of the Nutrition Program.

- Evaluation of the Advocacy Assistance Program - The overall objectives of this program are: to determine the system-wide response to the 1978 amendments to Title III, Part B of the Older Americans Act in regard to legal services and ombudsman services; to assess whether the delivery systems developed as a result of the legislation meet the objectives of the legislation; and to examine if the existing service providers meet the legislative objectives in an effective and efficient manner. Findings indicate that the field confirms that the need for legal services by older persons has been demonstrated. For the ombudsman program, all states are delivering or moving toward the delivery of statewide services. Although there are a range of structural variations, all ombudsman systems were found to be providing responsive and relevant services.

- Evaluation of the Title IV-A Career Training Program in Aging - This evaluation studied the impact of the Title IV-A Career Training Program and found that the program reached 14,000 students. Over 6,000 students pursued majors in gerontology or a related field.

- Analysis of Food Service Delivery Systems used in Providing Nutrition Services for the Elderly - This project is studying unit costs of providing meals to elderly persons and the reasons for variations in costs. Factors such as the type of food service delivery system, urban/rural location of projects, and the quality of meals are examined. The study also investigates potential areas for cost containment related to these factors.

- Evaluation of Health Fairs - This evaluation assesses sponsors' reactions to the Older Americans Health Fair Program and analyzes this information and other available data so that maximum learning from program experience could be obtained. Area Agencies and Red Cross Chapters worked with a diverse selection of community groups in sponsoring the First Older Americans Health Fair Day in May 1979 with oversight provided by the National Health Screening Council for

Volunteer Organizations, Inc. In 38 States, the District of Columbia, and two territiories and at 339 community sites in 176 planning and service areas of the aging network, eighty thousand older people were served. The study evaluates this cooperative effort.

FY 1980 Evaluations

- Analysis of Means of Identifying Needs of the Elderly for Services Under the Older Americans Act - This evaluation study, sponsored by the Federal Council on Aging, provides approaches and obstacles to the definition of "greatest economic or social need" in the general context of social service targeting and in the specific context of the implementation of the 1978 Older Americans Act amendments at the State level. The study's focus is on the mandated targeting phraseology of the Older Americans Act, and its reflection in intra-state funding formulae and State plans. The study analyzes definitions, procedures, and data resources which are part of States' design and development of funding formulae and State plans. A series of policy and technical recommendations are presented based on study findings and conclusions.

- Community Services Systems Development - This study provides information on evaluation design options for assessing community progress in developing systems of services for the elderly and for assessing the progress of State Units on Aging and Area Agencies on Aging in fostering the development of such systems. The study is part of the longer, mandated Federal Council Evaluation of Older Americans Act Programs.

- Low Income and Minority Elderly Participation in Older Americans Act Programs - This Federal Council on Aging study in analyzing low income and minority participation in Older Americans Act Programs, examined the accuracy of the Administration on Aging's data reporting system. The study also looks at the Administration on Aging's and the Office of Human Development Services' efforts to improve the reporting system and makes recommendations for further changes.

- Evaluation of Older Americans Act Programs under Title V (Senior Community Service Employment Program) - As part of the Federal Council's mandated evaluation of programs under the Older Americans Act, this study examines the efficiency, effectiveness, and responsiveness of Title V program activities. The Study Evaluates Title V efforts to place poor persons 55 years and over with poor employment prospects in part-time community service employment.

- Key Issues Affecting Older Persons in Long-term Care - This Federal Council on Aging study describes a population group with special care needs for extended periods of time and identifies key issues which policy makers and program planners should take cognizance of in the delivery of long-term care services. In developing the key issues, the study looks at the delivery of services for extended periods of time to at-risk persons.

- Location of Nutrition Sites Relative to Concentration of Low-Income and Minority Elderly - This evaluation study was designed to determine if nutrition sites are located near concentrations of low income and minority populations. It uses census data and a random 10% sample of the 11,500 nutrition sites to determine if the sites are located near low income minority populations.

- Evaluation of the Differences in Needs and Service Programs for the Rural Elderly - This study required by Section 411(b) of the Older Americans Act is related to the differences between rural and urban elderly for services assisted under the Older Americans Act. The three phase evaluation deals with differences in unit costs, service delivery, and access and special needs of the rural elderly, and their general health statu. Transportation and other issues which are general constraints on services to the rural elderly are explored. The first phase concluded with findings from research studies of Title III services. The second phase will analyze existing data on unit costs and resolve complex research issues the study must address. The final phase involves a field study and survey.

- Evaluation of the National Long-term Care Channeling Demonstration - The evaluation of the Long-term Care Channeling Demonstration was initiated to determine the effects of the channeling demonstration projects. The evaluation was designed to provide national policy and program insights. The study selects comparison groups and develops data on individuals, families and communities, to assess the impact of the demonstrations. Quantitative and qualitative information also are used to evaluate the impact of each project in relation to its catchment area and relative to all other projects in the national program.

- Congregate Housing Services Demonstrations - This study, cosponsored with the Department of Housing and Urban Development,is examining the process involved in establishing congregate housing projects and the performance of the projects in reaching target groups with services appropriate for individual needs. The study also assesses the impact of the program on its participants.

Question: What is the total funding amount for each of these studies?

Answer: The evaluations described above have received funding as follows:

FY 1978

Evaluation of the Implementation of Title XX (Jointly funded with the Administration for Public Services)	$ 75,000
Evaluation of "Over Easy"	$190,000

FY 1979

Longitudinal Evaluation of the Nutrition Program for the Elderly	$90,000

Evaluation of the Title IV-A Career Training Program in Aging	$ 49,000
Evaluation of the Advocacy Programs Funded under Title III of the Older Americans Act	$ 335,000
Analysis of Food Service Delivery Systems Used in Providing Nutrition Services to the Elderly	$ 476,000
Evaluation of National Health Fair Day	$ 75,000

FY 1980

Evaluations conducted by the Federal Council on Aging	$ 475,000
Analysis of the Means to Identifying Needs of the Elderly for Services under the Older Americans Act	($100,000)
Evaluation of Community Services System Development	($150,000)
Low Income and Minority Elderly Participation in Older Americans Act Programs	($ 50,416)
Evaluation of Title V Program	($ 75,000)
Key Issues Affection Older Persons in Long-term Care	($100,000)
Location of Nutrition Sites Relative to Concentration of Low-income and Minority Elderly	$ 58,000
Evaluation of the Advocacy Programs Funded under Title III of the Older Americans Act	$ 354,000
Evaluation of the Differences in Needs of Urban and Rural Elderly	$ 258,000
Evaluation of the Channeling Agency Demonstrations	$ 1,800,000
Congregate Housing Services Demonstrations	$ 500,000

Question: What Departmental offices are responsible for managing these studies?

Answer: The Administration on Aging manages the evaluations described above, with exception of the five projects listed above and which are managed by the Federal Council on Aging.

Question: What program evaluation projects are planned for Fiscal Year 1982?

Answer: The budget amount for this program is currently under discussion within the Reagan Administration. After the revised budget is forwarded to the Congress, we will provide an appropriate answer to this question.

OLDER AMERICANS ACT - GRANTS TO INDIANS

Question: Do you have any estimates of how services to Indians have improved as a result of the $6 million annually appropriated specifically for Indians under the Older Americans Act?

Answer: Funding under Title VI of the Older Americans Act was not available until FY 1980. In September of 1980, 85 awards were made to tribal organizations for services to elderly Indians. Since the awards have been made so recently, no evaluation has been possible to date.

Data contained in the applications submitted by the tribal organizations reflects that the greatest portion of Title VI funds would be used for nutriton. Lesser amounts were budgeted for transportation, legal services, a variety of other services and administrative costs.

In FY 1981, we will be funding an evaluation of this program which will address improvements in services to older Indians as a result of Title VI Program.

Question: What is the estimate of how many more Indians and Indian tribal organizations are being served now than were being served before the first Grants to Indians Appropriation in Fiscal Year 1980?

Answer: Funds in FY 1980 were awarded to 85 tribal organizations serving 20,000 older Indians. We have no information on how many of the 20,000 had been served by Title III Programs previously.

However, in 1979, 63,500 elderly Indians received benefits under the social service programs of Title III, and 51,700 received services under the nutrition program - for a total of 115,200 individuals.

Question: What is the average amount of each award to tribal organizations?

Answer: On an average, tribal organizations received $70,600 in FY 1980. Awards ranged from a minimum of $65,000 to $100,000.

Question: What has been the effect of the provision for reallotment of funds in States which receive Grants to Indian Funds? How many States have lost basic State grant funds as a result of the reallotment?

Answer: Funds in FY 1980 were awarded to Indian tribal organizations in 23 States. Pursuant to Section 604(d) of the Older Americans Act, funds allotted in FY 1981 took into consideration the number of Indians receiving services from the amounts available under Title VI which had been counted for the purpose of allotments under Title III. Ten States received reduced funding as a result of the reallotment. There was no effect on the funding received by the 20 States which receive minimum funding (as specified in Section 304(a)(1) of the Older Americans Act) and 27 States received additional funds.

UTILIZATION OF AGING RESEARCH FINDINGS

Question: One of the major problems with much Federally supported Research and Demonstration Projects is that their results are not disseminated to the field and are not utilized in policy formation. What steps has the Administration on Aging taken to assure that results of Research and Demonstration Projects it supports are being fully utilized, specifically by the network of State and Area Agencies on Aging?

Answer: The Administration on Aging has taken specific steps to assure that results of Research and Demonstration Projects, it supports are being fully utilized, especially by the network of State and Area Agencies on Aging. In 1980, $598,000 was expended specifically for dissemination and utilization activity. In 1981, new start funds in training, education, research and model projects designated for dissemination and utilization activities amount to $1,426,000. Funds are awarded to analyze and synthesize the lessons learned from these demonstrations and to summarize research and demonstration findings and make them available to potential users in a format responsive to their "knowledge and practice" needs. Current efforts involve such areas as community care systems, social services, services to the homebound elderly and informal supports. Additional grants and contracts were awarded for provision of technical assistance organized to communicate research findings to those seeking to improve programs. Administration on Aging staff is assigned to dissemination activities, conveying data through conferences, meetings, information memoranda and the Clearinghouse.

Also, the policy Study Centers and Long-Term Care Gerontology Centers funded by the Administration on Aging have been designed to provide technical assistance and dissemination from a multi-disciplinary approach which aggregates findings from all sources including research, and model projects. In addition, the Administration on Aging believes that the key to utilization does not begin only at the completion of a projects, but that efforts to insure utilization begin at the conception of a study and persist through its review and award as well as through its operation and completion. This is accomplished through the encouragement of input from State and area agencies into the development of research priorities and through "works in progress" presentations at national conferences including the Training Conference of the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

Question: How are the results of these projects being communicated to the newtork?

Answer: Dissemination and Utilization of research results is a complex multi-faceted effort. As indicated in the previous question, it begins with the very conceptualization of projects and the initial dissemination and utilization plan in the application, and continues with a wide variety of efforts after a project is funded. Synthesizing, aggregating, abstracting and packaging research and demonstration findings make it possible to transmit important research and demonstration findings not only to the network but to an even wider audience of potential users. It is indeed an indirect form of the Administration on Aging's advocacy mandate in the larger sense.

The following highlight a few of the most salient activities aimed at disseminating research and demonstration findings to facilitate their utiliztion by the field and to enhance their impact beyond the network. The results of research and model projects are being communicated to the network in a number of ways. The award winning AGING Magazine, published by the Administration on Aging, goes to everyone in the network six times a year and highlights information on research findings and model projects. Older Americans News is a monthly periodical which publicizes significant findings, as do a variety of National Clearinghouse fact sheets and other publications. Conferences such as the National Conference on Abuse of Older Persons include presentations of important research findings. State and local newsletters also incorporate and disseminate such information.

Other major effors of prime importance include awarding funds to the Gerontological Research Institute to insure that research findings are transmitted to the field in usable form. Most significantly,the entire Older Americans Act Regional Education and Training Program was designed to strengthen the linkages in the field which will assure timely and effective dissemination and utilization of the knowledge and products developed through our research and demonstrations. Handbooks on service development in a variety of areas such as transportation, nutrition, and in-home services are developed and made available to the network. Funds are also used to help potential users apply the results of research to improve services.

Evaluation studies are a specific type of research which is used directly to influence policies and guidance affecting the network. These findings are incorporated in program management and service delivery improvements.

We have also established new requirements and processes to emphasize the importance of communicating research and demonstration results not only to the network but to all potential users of such information. Grant applicants are required to include a dissemination and utilization plan as part of their application. We are now in the process of developing a new system for reviewing the results of research and demonstration projects and identifying findings which are most amenable to immediate use.

The Administration on Aging's multi-faceted approach to dissemination of research findings makes it possible to reach the network through a number of channels using a wide variety of information media and agents. In fact, we reach well beyond our own network as commerical media publication of research findings (even when the Administration on Aging is not recognized as sponsor) such as those related to hypothermia and elder abuse.

Question: What proportion of the research funds (not including Model Projects or Evaluation Funds) has a direct relationship to improving the Title III network of State and Area Agencies on Aging?

Answer: In light of the mandates and role of State and Area Agencies on Aging in advocacy and service management, one could consider the entire program or at least the great majority of research as having a direct relationship to improving the Title III network of State and Area Agencies on Aging. The discretionary programs where designed to provide the knowledge base for the advocacy and service management role of the network. Most important, it serves to provide understanding of the client and client needs. The knowledge produced and aggregated over time from these programs is translated into more effective and efficient network operations.

Techniques for needs assessment, planning, outreach, information and referral, location of nutrition sites, program development, indeed every facet and component of State and Area Agency operation uses the knowledge generated. Research also has helped the Network in developing outreach and services for special populations, such as disadvantaged minorities and impaired older persons, under unique conditions.

Other specific examples include:

Advocacy - The Institute of Gerontology at the University of Michigan completed a study which documented the extent and severity of abuse of the elderly. This research has been used by policymakers, practitioners and community leaders. At least twenty state legislatures have used the project findings to help develop legislation for mandatory reporting of elderly abuse.

Client Services Needs - The Fort Lincoln Family Medicine Center and the Distrisct of Columbia General Hospital used the findings from a Georgetown University Project ("Maintaining the Elderly in the Community ") to develop training courses and assessment procedures for the elderly for State and Area Agency use.

Program Development and Management - Staff with Portland, Oregon's Holladay Park Hospital Geriatric Day Program and ACTION/Foster Grandparent Program for Handicapped Children have both received technical assistance from Portland State University researchers on program management.

The above are only a few brief examples of the strong link between aging research and improving program development and management.

Question: Present this data for the last five fiscal years.

Answer: During the past five fiscal years the proportion of research funds awarded to projects which have a direct impact on the management of State and Area Agencies on Aging has been as follows:

FY 1980 - 80%
FY 1979 - 55%
FY 1978 - 32%
FY 1977 - 32%
FY 1976 - 18%

SPECIAL (MODEL) PROJECTS ON AGING

Question: The General Accounting Office reported in October of 1980, that less than half of Administration on Aging Model Projects continued to serve the elderly after Federal funding stopped. What can be done to give more attention to funding Model Projects on Aging which have potential for continued funding after the demonstration phase has been completed?

Answer: It should be noted that a continuance rate of approximately fifty percent is a very high rate for a program which is concerned with the encouragement of innovative ideas. Clearly, the more innovative the model, the more risky the probability of its succeeding. It should also be noted that the rate of continuation would have been higher than fifty percent if the General Accounting Office had excluded those projects which it stated were not intended for continuation.

During the past several years, the Administation on Aging has considered various ways to ensure continuance of Model Projects beyond their original Federal funding period. In the most recent funding cycle, September, 1980, two strategies were employed. First, in some projects eligibility was limited to State and Area Agencies on Aging. It was assumed that these established organizations would have a vested interest in seeing that certain projects for which they were responsible during the demonstration phase would be continued, either by that agency or spun off to an appropriate agency or provider at the end of that phase. Secondly, for all projects, the applicant's matching share, which is normally at least five percent of total project costs or fifty percent of indirect costs, whichever is greater, was increased to ten percent of total cost in the first year, and twenty percent and forty percent for each of the two successive years. The Administration on Aging anticipated that a project required to obtain an increasingly larger share of its funds from local sources would gain sufficient support to ensure its continuance beyond the original project period.

Three items in the criteria for review and evaluation of model project proposals are directed toward ascertaining the probable continuation of projects. Applicants are rated on (1) the experience of their organization in conducting related activities, (2) plans for continuance of services which will be generated by the proposed project beyond the termination of financial support from the Administration on Aging ; and (3) commitment from collaborating agencies and organizations evidenced in the proposals. These three factors comprise twenty percent of the total score on which an application is rated.

In the future, we could, and are expected to, consider the following options to increase the likelihood of continuance beyond the Model Project funding period: (1) continuing the practice of a grantee contributing increasingly larger shares of local matching funds; (2) increasing the weight of the evaluation criteria for continuation so as to be a greater percentage of the ranking score; (3) requiring substantive comments by State and local Agencies on Aging for all applications; and (4) requiring area agencies to submit a statement on how they will work with the project to ensure its survival beyond the original funding period if it succeeds in being funded. As the General Accounting Office's findings have indicated, where the area agency is involved in someway, chances for survival are enhanced.

Question: When State and Area Agencies on Aging are requested to give support for a demonstration project, how do you assure that this is not simply a paper approval, and that these agencies would be willing to give consideration to continuing the demonstration after the initial Federal support has been terminated?

Answer: Some years past, when State and area agencies were requested by applicants to provide support letters in their application for Model Projects funds, some sent routine letters of support with little substantive meaning; they always recommend edapproval. Two procedures have been instituted to guard against simple paper approval. First, State and area Agencies are asked to submit in-depth comments directly to AoA on each Model Projects proposal in the geographic area for which they are responsible for use only by the staff, panel reviewers and the Commissioner in recommending and making project awards. State and area agencies have been taking the opportunity to make more meaningful comments on project proposals. Requests for comments are formally solicited through an Administration on Aging Program Instruction.

Another procedure designed to ensure that State and area agency support is more than tacit is to give points for concrete evidence of collaboration with other agencies. This criteria, along with all the other rating criteria, are clearly listed in the Guidelines and Information Statement for applicants and grantees. For purposes of project review, a large number of letters of support is no longer sufficient evidence of commitment of potential community support. Committment is taken to mean presence of collaborative agreements or financial support from other agencies.

Question: What are some examples of successful model projects which have continued after the demonstration phase?

Answer: Some examples of Model Projects which have been continued after the demonstration phase are:

. Washington, D.C. The Home Caring Council developed and demonstrated in six communities a system to develop and improve home maker and home health services in the homes of the elderly. Since the completion of this project, its benefits are not only the continuation of better services in those limited geographic areas; but the approach and materials are being used in national and international seminars with benefits reportedly accrueing to millions of older persons.

. The Continental Association of Funeral and Memorial Societies, Incorported, developed, and field tested materials and techniques to educate the elderly particularly low-income and minority elderly) on funeral costs and services and on alternatives to the present high cost of funerals and burials. Although the project was completed last year and funding from the Administration on Aging has been exhausted, the project is making these materials available and providing training in the techniques nationally. The 180 volunteer-staffed memorial societies around the country, able to receive these materials and training, will in turn develop community education activities that will help educate consumers about funerals across the nation.

. Lubbock, Texas-- The Texas Technical University conducted a Demonstration which established homemaker services in a large rural area. Under-employed older women were recruited and trained and assigned to clients in the areas where they lived. Feed-back on how the program was working came from circuit court judges, county supervisiors and others who agreed to supplement the loose supervision mandated by the scattered location of clients separated by many miles. After the demonstration phase, a non-profit health agency assumed responsibility for continuing the services. In addition, the Utah Division on Aging then employed the project director as a consultant to help them establish a similar program in that State. She continues to respond to inquiries on specific aspects of the project from a variety of interested persons in other States.

. The multimillion dollar KQED daily television program carried by most Public Broadcasting System stations across the nation has continued for several years following initial support from the Administration on Aging.

. The National Health Fair Program for older Americans, developed through an awrd to the National Health Screening Council for Volunteer Organizations, Incorporated. In 1979, Model Project funds were granted to organize and demonstrate a health fair week for Older Americans in cooperation with the Public Health Service, and partially supported the programs 1980 costs. By 1981, the costs of an expanded program were underwritten from private sources, particularly The Prudential Insurance Company, and the program time-frame was extended from one week to an April/May and September/October emphasis.

SPECIAL PROJECTS IN COMPREHENSIVE LONG-TERM CARE

Question: The National Long-term Care Channeling Demonstration Program was funded for the first time during fiscal 1980. We understand that there have been a number of "Channeling" agency type demonstration projects which have been funded over the past several years by the Health Care Financing Administration. How do the new projects differ from those which have been funded by the Department in the past?

Answer: Twelve states were awarded contracts to conduct Channeling demonstrations under the National Long-term Care Demonstration Program begun late in 1980. Channeling refers to a set of community level functions and organizational structures that encompasses 1) case finding; 2) comprehensive client assessment; 3) case management; and 4) monitoring and reassement.

Projects have and are being funded by the Health Care Financing Administration that share many, if not most, of the primary elements embraced in the Channeling concept, for example, client assessment and case management. Such projects include:

1) Wisconsin Community Care Organization Project

2) New York State Long-termCare Home Health Care Program - Nursing Home Without Walls.

3) Oregon FIG Waiver Continuum of Care Project for the Elderly

4) Connecticut TRIAGE Project

5) Georgia Alternative Health Services Project

6) Monroe County (N.Y.) Long-term Care Program, Inc.

The last three projects listed, located in Connecticut, Georgia, and Monroe County are noteworthy for their close parallels in design and objectives to the new Channeling projects under the National Long-term Care Channeling Demonstration Program. Thus, the projects funded by the Health Care Financing Administration, as individual case studies will offer suggestive findings on two propositions decisive to the Channeling program:

1) Channeling will insure that a client receives needed Long-term care services.

2) Channeling will result in patterns of care more beneficial and less costly than the currrent Long-term care system which overemphasizes institutional and acute medical care.

What distinguishes the National Long-term Channeling Demonstration Program from the projects funded by the Health Care Financing Administration is its attempt on a national scale to test systematically whether Channeling is a cost effective method of arranging for services to functionally impaired older persons. By building standardized program elements into each of the twelve projects, by gaining their acceptance of common assessment and evaluation tools, and by ensuring that data will be collected and reported through uniform procedures, we have a basis for making valid comparisons and determining what answers are provided by the accumulated evidence.

In short, the few earlier projects offer some leads to whether Channeling works and why. The new National Demonstration Program is intended to give full answers to these important policy questions.

Question: What has been learned from similar demonstrations which have previously been funded?

Answer: Only one of the projects funded by the Health Care Financing Admimistration (the Wisconsin Community Care Organization) has been completed, albeit several others are near completion with final reports expected this year.

The Wisconsin project offered varied findings on the effects of using a continuum of health and social services to keep an aged and disabled population in their own homes or in community settings. Compared to matched control groups, those served under the Wisconsin projects were often better or equally well off, rarely worse off, at the end of the project. Public (i.e. government reimbursed) costs of their care was less, sometimes markedly less, than the costs of care for the comparison groups.

Preliminary findings from the Georgia, Connecticut, and Monroe County (N.Y.) projects are generally positive, as well. But the evidence is particular to each setting, resists cross comparisons, and provides no conclusive results on the effects of Channeling.

Question: Has enough information been generated from previously funded demonstrations to make legislative or programmatic changes to improve the long-term care system without expending more funds on demonstration projects of this type?

Answer: The HCFA demonstration projects do not provide sufficient information on the cost-effectiveness of long-term care services and a basis for legislative and programmatic changes at Federal, State and local levels. The systematic evaluation built into the new National Long-term Care Demonstration Program is intended to produce results as a basis for such decisions.

CHILD DAY CARE REGULATIONS

In the first Continuing Resolution passed last year and in the Reconciliation Act, Congress delayed the date for implementing the new Federal Day Care Regulations until at least July 1, 1981. Many members feared that these regulations were very costly and might reduce the quantity of day care services available to working parents.

Question: What is the new Administration's view of these regulations?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

Question: Does it plan to implement them?

Answer: The implementation of the regulations is dependent upon Congressional and Departmental actions taken in response to their review. If regulations are in effect, the Department must implement them.

Question: The Federal regulations were drafted in order to assure a minimum standard of quality in day care. What steps does the Office of Human Development Services take under current law and regulations to make sure that Federal dollars do not pay for substandard day care?

Answer: The effective date of the Health and Human Services Day Care Regulations has been delayed until July 1, 1981. Day care facilities currently must meet State standards to be eligible for Title XX funds. State Title XX day care staff enforce the applicable standards in their State, and the Office of Human Development Services must assure that the States are enforcing those standards. Title XX auditing staff must determine that costs are allowable for reimbursement. If standards are not met, a disallowance is taken.

HEAD START

In Fiscal Year 82, the Office of Management and Budget projects that Head Start will receive: $79.1 million from the U.S. Department of Agriculture for child nutrition programs; $26.9 million from the Comprehensive Employment and Training Act (CETA) to hire Head Start staff; $12.1 million from Title XX social services.

Question: What do you project will be the effect on Head Start of proposed decreases in funds available through the above three programs?

Answer: Virtually all Head Start projects receive reimbursements under the Department of Agriculture's Child Care Food Program or School Lunch Program. Proposed changes in the Child Care Food Program which would eliminate reimbursements for nutritional supplements (snacks) would result in a reduction of approximately $9.7 million in nutritional benefits for Head Start children.

Based on data from local projects, we estimate that CETA supported workers are employed in nearly half of all Head Start programs. The occupations filled by CETA paid workers in the Head Start program include teachers, teacher aides, bus drivers, social service aides and clerk typists. If CETA is eliminated, Head Start will lose up to $26.9 million dollars worth of staff help in FY'82. Most jobs supported with CETA funds are essential to the operation of Head Start projects and would have to continue to be supported with Head Start funds.

According to data from local projects, 223 Head Start programs supplement their funds with Title XX monies. The average Head Start program day is approximately five hours. Reports from Regional Offices indicate that a substantial portion of the Title XX funds received by Head Start are used to provide extended hours of service for child care in order to facilitate economic self support of families. In addition, the majority of Head Start families depend on the social services provided through the Title XX program. If there is a reduction in Title XX funds, many of the 223 projects receiving Title XX funds would be forced to reduce hours of operation or reduce social services, adversely affecting many of the approximately 40,000 children and their families who are associated with these projects.

HEAD START ALLOTMENT FORMULA

Question: Do you think there should be a change in the Head Start allotment formula, which effectively precludes two states from receiving any increase in funding beyond the FY 1978 level, and limits several other states to increases that are less than the increase in the cost of living provided by overall increases in appropriations?

Answer: We have not requested changes in the portions of the Head Start allotment formula which determine the distribution of funds among the states.

Prior to 1978 when the current Head Start statutory formula was developed, the distribution of Head Start funds among the states varied considerably from the relative population factors upon which the Congress wished to have the allotment based. One of the main purposes of the 1978 Head Start allocation formula is to produce, over time, funding allotments to states which equal 100 percent of what they are eligible for according to the states' relative share of the poverty population. The poverty population factor for each state is based, in equal proportions, on the number of children age 0 to 5 in families with incomes below the poverty line, and on the total number of AFDC recipients in each state as compared to all states. The formula moves states toward equity by restricting annual funding increases which go to those states that are currently "overfunded" in relation to their share of the national poverty/AFDC population. Each year these "overfunded" states receive increased funds at about half the rate of other states. In addition, states that are "overfunded" by more than 75% can receive no funding increase - only Mississippi and Alaska remain in this category.

The redistribution of funds which the 1978 formula was intended to achieve has largely been accomplished. Over the next authorization period, as more states qualify for full funding, there will be fewer problems of enrollment losses caused by funding restrictions. Significant enrollment losses can still be expected in Mississippi and Alaska. However, the portion of eligible children served by Head Start in these states remains high in comparison to the national average. In 1981, approximately 60% of eligible children will be served in Mississippi and 30% in Alaska, as compared to 19% nationally. These percentages have fallen from approximately 72% and 33%, respectively, in 1978.

We feel that continuing the current formula is an effective way to achieve a distribution of Head Start funds which is consistent with the formula Congress has defined.

Question: If the Head Start allotment formula were to be changed, what recommendations would you make?

Answer: The only area in which we would recommend change in the Head Start allotment formula concerns the manner in which cost-of-living increases are provided to Indian and Migrant projects. Cost-of-living increases for these projects is currently indexed to the Consumer Price Index. Under the proposed change, Indian and Migrant projects would receive an increase proportionate to the rise in the Consumer Price Index or the rise in the Head Start appropriation, whichever is less. This change is intended to ensure that budget increases for Indian and Migrant projects are not disproportionately higher than the increases available for other Head Start projects.

Question: How many states have had to cut back enrollments because of the funding limitations in the formula, and to what extent?

Answer: Between 1978 and 1980 enrollment in full year Head Start projects fell by 5,325 children. The national losses in enrollment were largely due to the fact that appropriation increases during this period did not fully offset inflationary price increases and projects were compelled to reduce enrollment in order to maintain program quality. The statutory allotment formula did, however, play a major role in determining the states in which these enrollment losses occured.

For the purposes of the allocation formula, which treats the District of Columbia and Puerto Rico as states, there are 52 states. During this period enrollment remained relatively constant in 21 states, increasing or decreasing by less than 100 children in each state. In 19 states there were enrollment losses of 100 children or more, while in the remaining 12 states there were enrollment increases of 100 children or more.

Question: Are there any states that have been unable to use all of the funds provided for their programs? If so, where has this occurred and how are these funds reallocated?

Answer: There have been no instances of states being unable to use all of the funds provided for their programs.

Question: How many States received full cost of living increases in their programs during Fiscal 1981, and how many will receive such increases in Fiscal 1982 at the level you have requested?

Answer: In Fiscal Year 1981, if Head Start, which is currently operating under a continuing resolution, receives its requested budget of $820 million, a funding increase of 11.1 percent nationally will be available to local projects to offset inflation and continue current services. Twenty-nine States will receive increases of at least 11.1 percent.

During Fiscal Year 1980 the Consumer Price Index rose by 12.7 percent. If it is assumed that the rise in the Consumer Price Index indicates the funding increase needed in Fiscal Year 1981 to fully offset inflation, there will be 20 States which receive a full cost-of-living increase of 12.7 percent.

In Fiscal Year 1982, an appropriation of $950 million has been requested. It has been assumed that a funding increase of 10 percent above Fiscal Year 1981 levels will enable projects to meet inflationary price increases. At this budget level we anticipate that a 10 percent cost-of-living increase will be available to all States, except Mississippi and Alaska which are precluded by the statutory formula from receiving any funding increases. To enable all eligible States to receive a 10 percent cost-of-living increase, we anticipate using funds from the Secretary's Reserve to supplement grants to approximately 15 States which would otherwise receive slightly less than a 10 percent increase.

MINIMUM WAGE FOR HEAD START EMPLOYEES

Last year the Department estimated that approximately 60 percent of the people working in Head Start programs were receiving the minimum wage.

Question: Is this figure still the same, and to what extent have increases in the minimum wage influenced program staffing?

Answer: As we indicated last year, our estimate that 55 to 60 percent of Head Start employees were paid the minimum wage was based on partial results of an informal wage survey. Since that time, we have gathered more complete data in preparing our Fiscal Year 1982 budget request and now believe that approximately one-third of Head Start employees are paid the minimum wage. Many more receive wages that are close to the minimum wage floor.

Head Start legislation requires that all staff in local projects be paid at least the minimum wage. Over recent years, funding increases for local projects have generally been adequate to keep pace with increases in the minimum wage without seriously affecting program staffing. However, through Head Start's statutory allotment formula, a number of States have received funding increases which have not been adequate to fully offset inflationary fund increases. Some projects in these States have had to reduce enrollment and eliminate staff positions. We do not have any evidence that minimum wage increases have been a major factor in causing such reductions.

Question: How many of the Head Start employees paid at the minimum wage rate are employed full time?

Answer: Because most Head Start projects operate for eight or nine months, few minimum wage workers are employed on a full year basis. A considerable number of minimum wage employees, such as classroom aides, kitchen workers or bus drivers, work less than an eight hour day because of the nature of their jobs. We do not have data to accurately estimate the number of minimum wage workers who are employed full time.

Question: How many Head Start employees receive wages that are less than the minimum wage?

Answer: Head Start legislation precludes projects from paying staff less than the minimum wage, and we know of only one project which is not adhering to this requirement. With the exception of this project, we know of no Head Start employees who are receiving less than the hourly minimum wage.

A project operated by the government of Puerto Rico pays some employees less than the minimum wage because the grantee contends that this is allowable under Puerto Rican law. The legality of this practice is being investigated.

Question: Has there been much change in employee hours and wage rates in those States that have not received increases sufficient to match inflation?

Answer: In States where funding increases have not kept pace with inflation, it is likely that there has been some reduction in the length of time staff work annually. Although this would reduce annual wages, we do not know of instances where hourly wage rates have been reduced. With the exception of Mississippi and Alaska, States in this group have, however, received some funding increases, a portion of which has been used to increase salaries. Data is not available which enables us to measure the exact effects on employee hours and wage rates of this combination of restricted funding increases and cutbacks due to inflation.

Question: Does part-time, or less than minimum wage employment influence staff turnover, and how does this affect program operations?

Answer: Salaries less than the minimum wage hourly rate are not paid in Head Start and part-time employment is appropriate in many Head Start jobs. Low salaries are, however, widespread and create serious problems in attracting and retaining qualified staff.

For example, a survey was conducted in the Spring of 1979 by our training and technical assistance staff of Head Start grantees in Kentucky to assess the extent of staff turnover. Twenty-five grantees responded to provide information on a total of 1090 staff positions. Results indicated that 23 percent of teachers and 50 percent of teachers aides leaving their positions with Head Start stated that they were leaving in order to pursue a higher salary or for professional advancement.

In addition, a recently completed study of 95 child care workers in San Francisco found that job conditions, not the nature of the work, was the chief reason that staff leave their jobs. Staff repreatedly labeled working conditions such as long hours, low pay and lack of benefits as reasons for feeling dissatisfied, frustrated and unable to make commitments to their jobs.

The high turnover rate among staff which results from low salaries affects program operation and children's learning. The child development and learning theory literature maintain that children need continuity of care during the early years. Young children need time to make the transition from home to Head Start and to adjust and become comfortable with alternative caregivers. When the preschool program is interrupted by the turnover of teachers, the continuity needed for the child is lost. This is likely to reduce learning and affect development outcomes.

In addition, it is well documented that experience and training of staff is crucial to the provision of quality care. It is often the most competent teachers, those with both training and experience, who leave the program due to a variety of factors including low salaries.

A combination of the above factors suggest that the high turnover of trained and experienced teachers in Head Start results in less competent staff and therefore, less effective programs for children. Several studies indicate that the level of competency of the classroom staff is the most important factor in the effectiveness of the program in affecting child development. The National Day Care Study (Abt, Associates, Inc., 1978) found that, in programs where the caregivers had specific training and experience in early childhood education, the children in their care scored higher on school readiness and cognitive and language measures. In addition, the study found that such trained and experienced caregivers engaged in more social interaction with children.

Data from the Head Start Supplementary Training/Child Development Associate Study (Kirschner, 1978) indicate that child development training results in an improvement in the way teachers work with children as well as parents.

The Summary of National Evaluation of Head Start 1966-69 (Data and others, 1976) found specific staff training in early education to be positively related to gains in school readiness in the children.

OVERDUE HEAD START REGULATIONS

Last year the Department testified before this Committee that Head Start regulations providing for local determinations of eligibility in certain remote areas would be proposed in July of 1980, and made final by December, 1980. These regulations have still not been proposed, and it is nearly three years since the law providing this option was enacted.

Question: What is taking so long?

Answer: We regret that we did not meet the planned December, 1980 date for the issuance of final regulations. We discovered that some communities outside of Alaska are potentially eligible to set their own eligibility requirements, so we have spent a considerable amount of time studying and seeking advice on the policy issues involved. We have also been informed that we have to secure OMB approval on the reporting requirements that are in the proposed regulations. Proposed regulations have been drafted. They are awaiting final comments from the Office of the General Counsel and will be published as soon as these comments are received and appropriate revisions made.

CHILD WELFARE RESEARCH AND DEMONSTRATION

A part of the budget justification for Child Welfare Research and Demonstration reads as follows:

> Research in this priority area is directed toward generating new knowledge about the development of children, youth and families; testing innovative approaches to strengthen and support the capacity of parents to meet the needs of their children and to act as effective and knowledgable consumers of community services; assessing and developing national policy concerning children, youth and families; and disseminating findings from successful demonstration and research efforts.

Question: What specifically do these projects fund?

Answer: The "Infant Temperament and Early Social Development" project is a longitudinal appraisal of temperament and social responsiveness in infant twins, including observations of infant-mother reciprocity in cases where two infants may differ markedly in temperament, and thus evoke quite different reactions from the mother.

The "Asian Child Development Project in the San Francisco Bay Area" is a needs assessment in the San Francisco Bay area of early development of children from families of Chinese, Filipino, Japanese, Korean, Vietnamese, and Samoan descent. Specific activities include 1) conducting survey of families, groups, and programs, 2) collecting secondary data from Asian social indicators, 3) analyzing data, 4) reporting and disseminating results, 5) preparing recommendations for service programs, 6) furnishing technical assistance in initiation of programs, and 7) initiating research into conflicts in childrearing due to difference between Asian and American value systems and institutions.

Another important project is a study called "The Psychological Effects of Custody Disputes on Children." In order to investigate the effects of custody disputes between divorcing parents on the psychological and social functioning of their children, this project is studying one group of families who settle the issue of custody out of court and one group of families who participate in a court trail. Families will be followed throughout court involvement and at least three years afterward.

A project called "Black Families Using Child Care: An Ecological Analysis of the Interaction Between Family Functioning and the Utilization of Three Alternative Forms of Child Care" is examining how the provision of child care through one of three alternative service delivery models affects black family functioning over time. It will determine which aspects of family functioning are associated with using child care in a completely subsidized center, child care purchased with a government-subsidized voucher, or child care paid for out-of-pocket, versus no child care.

The "Adolescent Pregnancy and Parenthood: Model Policy Development and Implementation" project will initially gather information on legislation, rules, regulations and policies of state boards of education and of social service, maternal and child health and family planning agencies in up to 50 states in order to analyze components dealing with school-age parents and their children. Findings will be codified into a system which will facilitate analysis of gaps, duplication, and evidence of interagency cooperation and coordination in order to develop model legislation, rules and regulations, and policies for agencies dealing with teenage parents. Later activities will include the determination of the relationshp between service delivery programs and policies, validation of the model policies developed in the first phase, and linkage of state policy makers with others in the area of adolescent pregnancy and parenthood.

The "Linking Institutional Networks with Community and Kinship Systems (LINCKS)" project is linking existing formal agencies and informal neighborhood support mechanisms into a community-based support network for minority, low-income teenage mothers. The Washington, D.C. Parent Child Center, a local neighborhood organization, and the neighborhood high school are expanding and reorganizing the delivery of services into a model program and will evaluate its effects on the study population.

Question: Why is research in this area a Federal responsibility?

Answer: The Federal support of research in the area of children youth and family development is able to cut across state and regional levels and to pool research results for the benefit of policy and service agencies across the country. The Federal role in collecting and disseminating knowledge about child and family development is critical to helping local and state levels improve their services. The research moneys concentrated at the Federal level permit for a focused approach to addressing knowledge gaps and can support those researchers best qualified to fill those gaps.

CHILD WELFARE RESEARCH AND DEMONSTRATION

The Child Welfare Research and Demonstration Appropriation pays for research in areas such as: Child Abuse and Neglect; Child Welfare Services; Day care; and Runaway and Homeless Youth.

Question: What coordination is there between projects in these areas under this appropriation and the various categorical programs which relate to these issues?

Answer: There is considerable coordination between ACYF research projects and related categorical programs. Child welfare research and demonstration projects have provided much useful information to program administrators. For example, we have learned, through research projects, that the number of children in foster care tripled between 1961 and 1977, that State Child Welfare Services had generally evolved into little more than foster care systems, and that 24-hour comprehensive emergency programs could reduce the need for foster care, to name just a few useful projects which were instrumental in providing an understanding of, and the need for revising, the Federal/State child welfare and foster care programs which Congress did in enacting the Adoption Assistance Act of 1980. Research in other areas, such as day care and runaway youth, has yielded similar benefits. It should be noted here that research in Child Abuse and Neglect is not funded by the Child Welfare Research and Demonstration Appropriation but rather through funds appropriated under the Child Abuse Prevention and Treatment Act of 1974.

Question: How is it at all possible to avoid duplication in the area?

Answer: The close coordination between personnel engaged in research projects and those in program administration, as well as the existing research requirements of the various categorically programs assure little, if any, overlap in these research projects. Furthermore, ACYF has a coordinated research planning process in which all proposed projects are thoroughly discussed by those personnel involved in the research functions of this agency.

CHILD ABUSE AND NEGLECT

Service improvement grants were authorized in 1978 as competitive grants to allow public and nonprofit groups to provide day-to-day child protection services in cases of immediate need.

Question: How many service improvement grants have been awarded?

Answer: The National Center on Child Abuse and Neglect has awarded 43 service improvement grants in the period from Fiscal Year 1978 through Fiscal Year 1980. It intends to award an additional 26 service improvement grants in Fiscal Year 1981.

Question: How many children and parents have been served by these projects?

Answer: Between April 1979 and January 1981, a total of 33,080 children in 16,224 families have been served by the 43 original service improvement projects funded in Fiscal Year 1978.

Question: What kinds of services are needed most?

Answer: Services provided by trained paraprofessional parent aides or lay therapists, peer support programs, respite child care and individual and group counseling services are most needed. In addition, NCCAN has found that child protective agencies desperately need the closely coordinated assistance of professionals from other service agencies, such as law enforcement in the case of child sexual abuse and mental health specialists for assessing the vulnerability of abused or neglected children and adolescents.

Question: How are these service improvement projects coordinated with activities under the State's (1) Child Abuse State Grant program; (2) Title IV-B (Child Welfare Services) Program; and (3) Title XX (Social Services) program?

Answer: In general, all service improvement grant applications are subject to review required under OMB Circular A-95, which generally gives public social service agencies responsible for carrying out programs under these three authorities an opportunity to comment on their usefulness or their potential duplication of existing services. Secondly, service improvement projects are meant to serve as vehicles for disseminating useful program approaches in a seed grant manner. They are aimed, from the outset, toward institutionalizing those approaches within local communities, using sources of funding other than the discretionary funds available through NCCAN. The projects thus are exptected to begin almost immediately to work with program officials administering ongoing services, funded by Title IV-B and Title XX, to insure the continuation of their "service improvements" at the end of the project periods approved by NCCAN. A third general point is that NCCAN has consciously targeted some service improvement funds to agencies other than public social service agencies in an attempt to use these funds as levers to gain greater interagency coordination of service delivery at the local and State level. The funds generated for child protective purposes through the Child Abuse and Neglect State Grant program, Title IV-B and Title XX are almost totally directed to programs within public social service agencies or contracted by them. Finally, NCCAN defines the service improvement part of its program as an extension of its developmental and dissemination mission to assist States and communities to find and implement better ways to prevent child abuse and neglect. Concomitantly, this thrust means that NCCAN's service improvement grants are aimed at installing needed community services which make it possible to prevent the unnecessary placement of children outside their own homes, (the major goal of the amendments to Title IV-B passed by Congress in 1980 as part of the Adoption Assistance and Child Welfare Act).

Service improvement projects in different States have taken varying approaches to coordination with the Title IV-B and Title XX services in their States. The proof of their effectiveness can be seen in the fact that nearly half of the service improvement projects begun by NCCAN in Fiscal Year 1978 have been expanded, or are being continued by using Title XX funds.

Question: Are these service improvement projects being evaluated?

Answer: The first 29 service improvement projects supported by NCCAN are being evaluated as part of a contracted research effort. The final report on eight of the child protective services improvement projects has been completed. Part Two of the evaluation-research study will be completed in the Spring of 1982, and it will address findings related to the other 21 projects.

Question: What has been learned from these projects?

Answer: The principal hypothesis was that small amounts of money can be used to enable already existing agencies to install program components for preventing and treating child abuse and neglect with the result that those agencies can succeed in initiating new services that improve their ability to respond to the problem and can continue those improvements past the project period supported by NCCAN funds. This hypothesis has proved to be valid. Furthermore, the NCCAN contention that child abuse and neglect requires a multidisciplinary and multiagency community response if it is to be controlled and reduced is being confirmed through these projects. Preliminary findings demonstrate that, through the leverage of NCCAN-funded service improvements, the increased involvement and support of health, mental health, educational, law enforcement, day care, and other kinds of organizations and agencies in child protective systems, has lightened the load of overburdened public agencies and increased the capacity of communities to support at risk families before they have to become "clients" of child protective services.

The wide variety of service improvements being supported by these projects hold promise of providing other new findings and information about specific program approaches, such as better ways to recruit, train and manage parent aide programs, improvements in multidisciplinary coordination efforts, special programs for rural areas, and use of minority "ombudsmen" in child protective cases involving minority clients. In fact, various projects are producing curricula, manuals and other materials which can be used in replicating the approaches which they have implemented.

The Child Abuse Prevention and Treatment Act requires that at least 50 percent of the appropriate funds be used for research, demonstration, and service grants.

Question: What is the difference between a research grant, a demonstration grant and a service improvement grant?

Answer: A research grant supports efforts to increase knowledge about the nature, extent, causes and effects of child abuse and neglect and to determine the comparative effectiveness of various program approaches. It is not meant to support the delivery of any kind of services. A demonstration grant supports the development and implementation of a given service approach or a particular service delivery system element in order to test out its usefulness in preventing or treating child abuse and neglect. Demonstrations provide the testing ground for innovative techniques and approaches under optimal and controlled circumstances. They demonstrate feasibility, cost-effectiveness and potential for replication. An important part of a demonstration project is the concurrent research and/or evaluation of its services which is intended to document the value of the approach tested and to define those features of the program which may be replicable. In addition, demonstration projects often provide case data which can be used in related research efforts. A service improvement grant supports the installing or implementing of a program component into an already existing service agency or organization in the fashion of "seeding" program improvements. The program improvements which are supported are often based on findings from demonstration projects. Service improvement grants represent the tailoring of existing services to the program needs of abusive and neglectful families, using service approaches already demonstrated to be effective.

Question: Give examples of each.

Answer: Examples of research grants are the current projects on "Longitudinal Research on the Causes and Effects of Child Abuse and Neglect," each of which is looking retrospectively at client records to discern intergenerational patterns of child maltreatment. NCCAN is also supporting three research grants related to needs and resources for child protection in residential institutions. Examples of demonstration grants are the 19 demonstration Clinical Treatment projects, which are testing intensive and specialized treatment approaches for families involved in different forms of child abuse and neglect. Another example is the demonstration of improvements in juvenile court's handling of child protective cases, being carried out by four court systems (located in Louisiana, Arizona, California and the District of Columbia). Examples of service improvement grants are the recently completed set of eight grants to public child protective agencies and the 21 grants to a wide variety of service agencies for addressing an array of approaches to prevention and treatment. Also, eleven service improvement projects are addressing improvment of investigation into, and treatment of, child sexual abuse by social service, court and law enforcement agencies.

Question: What criteria are used for awarding these grants?

Answer: The basic criteria are: (1) the capability of the applicant organization to carry out what it has proposed to do; (2) the objectives and the benefits expected of the proposed work; (3) the workplan or methodology for accomplishing the work; (4) the quality of staff proposed to carry out the work; and (5) the reasonableness of the proposed budget. For each category of grant, there are specific other criteria which are spelled out in the Program Announcement, published in the Federal Register, which solicits proposals. In almost every case a demonstration or service improvement grants, NCCAN requires evidence of community coordination, especially with public child protective services, as a condition of award. It also requires submission of quarterly reports and agreement to work cooperatively with NCCAN evaluations and to meet with NCCAN staff and other grantees once each year for joint consultation and planning. Finally, NCCAN adheres to the direction contained in the Child Abuse Prevention and Treatment Act (P.L. 93-247, as amended) that it award grants with equity among the States.

Question: How does the peer review process for reviewing grant applications work?

Answer: NCCAN requests that Regional Office officials submit names of professionals from a variety of disciplines around the country to serve as reviewers. Reviewers, numbering as many as 150 individuals, are each asked to review approximately 15 applications, and to rate them and comment upon their strengths and weaknesses using review forms provided to them. Each application is read by no fewer than three reviewers. Due to the prohibitive costs of travel, the reviewers do not meet together to discuss their evaluations of the applications, except in rare situations. The scores of the reviewers are computed, using a Standard Mean Score process, and the scores of applications are ranked in numerical order. This serves as the reviewers' set of recommendations to the Commissioner of the Administration for Children, Youth and Families for awards. Staff review the top-ranked applications and make recommendations based on geographical distribution and variety of projects (to avoid inappropriate duplication of types of programs funded).

Question: Are there different panels for research, demonstration and service improvement grant applications?

Answer: NCCAN does use different panels, not only for these three categories of grants but also for the different types of research, demonstration and service improvement which it funds in any given fiscal year. An attempt is made to match the reviewers' interest and expertise to the subject addressed by the grant type.

CHILD ABUSE AND NEGLECT STATE GRANTS

In order to receive Child Abuse and Neglect State Grants, States must meet certain statutory requirements.

Question: What are these requirements?

Answer: The ten requirements which States must meet to be eligible for Child Abuse and Neglect State Grants are: (1) State law must provide immunity for reporters of child abuse and neglect;

(2) State law must provide for reporting of known or suspected child abuse and neglect; (3) States must provide for prompt investigation of reports and the taking of steps to protect children in danger; (4) States must have procedures, trained personnel, and multidisciplinary programs necessary to deal with child abuse and neglect; (5) States must assure confidentiality of records of reports; (6) States must provide for cooperation with law enforcement officials, courts of competent jurisdiction and other State agencies; (7) States must insure provision of a guardian ad litem for each child whose protective case goes before a court; (8) States must provide for a maintenance of effort to insure that the State grant will increase the level of support rather than supplant it; (9) States must insure dissemination of information on prevention and treatment of child abuse and neglect; and (10) States, to the extent feasible, must give preferential treatment to parental organizations combatting child abuse and neglect.

Question: What provisions of the Child Abuse Prevention and Treatment Act are the hardest for the States to comply with?

Answer: The hardest requirements are: (1) the provision of guardians ad litem for all child protective cases going to court; and (2) the enactment of laws which provide for reporting of child abuse and neglect using the specific definitions of child abuse and neglect. Specifically, on the latter point, States have had problems enacting legislation requiring the reporting of "mental injury."

Question: What assistance does the National Center on Child Abuse and Neglect provide to the States to help them come into compliance?

Answer: Direct technical assistance is provided by Regional and Central Office staff and legal consultants to each State contemplating legislative changes which might affect its eligibility. NCCAN has also developed a draft Model Child Protection Act and draft Federal Standards which provide guidance materials for use by States in meeting eligibility requirements. Specific technical assistance efforts of Regional Child Abuse and Neglect Resource Centers are aimed at ineligible States, involving public awareness, professional training and direct individualized technical assistance to accomplish eligibility. The National Resource Center for Child Advocacy and Protection, an NCCAN demonstration grant conducted by the American Bar Association, has also provided technical assistance to States on issues of eligibility.

Question: How does NCCAN monitor the States to ensure that they remain in compliance?

Answer: Monitoring is conducted through annual site visits by Regional Office staff to the States, through the recently instituted triennial State Child Welfare Program Review process, and through annual review of statements prepared by States documenting laws, procedures and programs which fulfill the statutory eligibility requirements.

Question: As more States come into compliance and as reported incidents of abuse increase, will an increasing proportion of funds be spent on grants to States?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administration's policy has been established, it will be provided to the Subcommittee.

CHILD ABUSE AND NEGLECT

It is obvious that both children and society as a whole are better off if child abuse can be prevented rather than treated after it has been discovered.

Question: How can child abuse be prevented:

Answer: A full answer to this question would be extremely lengthy and involve a certain amount of speculation. It is clear that child abuse, unlike some diseases, is not amenable to a simple vaccination-type prevention program. It springs from individual incapacities, internal family stresses, environmental and economic deprivations, and, to some extent, from a general cultural acceptance of violence as an acceptable solution to human problems. NCCAN has defined for itself a four-fold approach to prevention which appears to be useful in developing promising methods. Prevention under this conceptual framework, requires transmission to parents of (1) knowledge about parental roles, responsibilities and skills; (2) access to certain supports, such as educational, medical, mental health, recreational, employment and peer support resources; (3) motivation to use the resources and to gain the knowledge; and (4) support, especially in times of stress and especially from family, friends and neighbors. Among the most exciting of NCCAN's current projects are 11 demonstrations of primary prevention of child abuse across the country. They are devising, and NCCAN is studying, approaches to concrete, low-cost ways to implement these four parental supports.

Question: Some research indicates that financial stress and poverty are significant causes of child abuse. What are the implications of these findings for prevention of abuse?

Answer: These findings have implications for the targeting of resources -- both for preventive programs and for treatment. For instance, the need for family-oriented mental health and public health programs attending to parents and children in areas of high unemployment and low socioeconomic status should clearly take precedence over allocation of resources for such programs in communities where economic status and employment opportunities place fewer families at risk. Such mental health and public health programs, while they may in themselves be insufficient to stem the tide of stress-related child maltreatment, can serve as counterweights to those negative forces. In addition, a clear implication of these findings is that programs that provide direct help for families, relieving their need to provide constant child care to their children and providing them with opportunities to improve family income and learn new marketable skills, may be more effective than casework counseling or other traditional child protective services in helping families to change abusive or neglectful patterns of behavior toward their children.

Question: What specific services and resources are needed by families to reduce the likelihood of abusive behavior?

Answer: NCCAN is exploring possible answers to this question through its present primary prevention demonstration programs. Among the services being studied are: perinatal parent support and parent-child bonding programs, homevisit programs for parents of infants and very young children, information and referral services for parent-child support programs available in communities, and parent education programs, especially dealing with child discipline and parental coping skills. In terms of resources, NCCAN is convinced that programs already in place in most communities in this country can be focused to become effective preventive programs, given some reallocation of existing resources, appropriate program decision-making by local agencies, and proper training and skills for their staffs. Such agencies include public and private schools, day care centers, community colleges, community mental health centers, public and private health agencies, clinics, law enforcement agencies, and public and private social services agencies. Prevention of child abuse and neglect need not be labeled as such; it may be most effective if it is accomplished through a community-based effort to insure that families receive the assistance they need to serve as their children's principal caregivers and protectors, providing safety valves in times of family crisis and supplemental assistance in times of serious family need.

Question: What has been learned from the prevention projects funded by the National Center on Child Abuse and Neglect?

Answer: Perhaps the most important finding so far, based on the still incomplete experiences of the 21 Community-Based Child Abuse and Neglect Prevention and Treatment projects and the 11 Demonstration Primary Prevention projects, is that families voluntarily will seek and make use of family supportive help to avoid causing harm to their children. Peer support groups, group counseling, parent education courses, use of paraprofessional parent aides, use of homemakers, individual and marital counseling, and other programs supported by these projects have been filled to capacity. One factor contributing to the success of these programs in attracting parents and children to their services -- and in preventing family break-down and violence through their services -- has been their frequent use of public awareness through the media. A message has been generated in many communities now that "Being A Parent is One of the Toughest Jobs in the World," with the concomitant message that it is all right to need and to seek help before a child gets hurt.

A preliminary finding in one primary prevention project holds hope that intensive prenatal and postnatal parent support programs provided to very young parents in a rural section of the country can prevent infant battering. The National Center for the Prevention of Child Abuse and Neglect at the University of Colorado has previously indicated this same hopeful finding in a program it conducted in Denver. This program involves effort to convince obstetricians, pediatricians, and nurses to change their approaches to assisting in the birth of babies so that parent-infant bonding is facilitated rather than interrupted by their professional assistance.

Another tentative finding is that the first line of prevention services is probably at the neighborhood level and may best rely on community-based organizations and (in some cases) natural helping networks. Preventive programs are not only cost-effective in terms of the costly remedial services which they can prevent, but also in terms of the fact that they do not require the mounting of large new programs or hiring of large staffs of professionals.

The child sexual abuse prevention through education projects are all finding that ignorance on the part of children with regard to the existence of sexual abuse as well as what to do if they experience it has probably made young children more vulnerable than they would learning that the incidence of unreported child sexual abuse (of both girls and boys) is as much as two to three times higher than our estimates have shown it to be.

For FY 1980 and FY 1981, $6.9 million were appropriated for Child Abuse and Neglect State Grants.

Question: What good has this marginal amount of Federal Money achieved?

Answer: The State Grant programs has been viewed as a developmental resource for States to use in efforts to improve their child protective service systems or to initiate new program components. At the end of three years, States are expected to continue programs begun with these funds with other resources, if appropriate, and to use the State Grant funds for additional new developmental purposes. We believe these grants have often had a significant impact. For example;

In Maine, a Comprenhensive Emergency Services project was funded in the Augusta area, with an after-hour telephone intake and response capability. After one year, and the death of a child in another area of the State, the project was extended statewide, using other funding and has been in operation for the last three years.

In New Hampshire, a parent aide project was funded in one area of the State, which resulted in the Statewide New Hampshire Task Force on Child Abuse and Neglect establishing the Volunteers in Protective Services project statewide, using Title XX funds.

In Massachusetts, three Comprehensive Emergency Services projects were funded for six month start-up periods, to a community mental health center, a private child protective agency and a local office of public child protective services. All three have been continued with Title XX funds and have been operational for two years.

In Connecticut, we funded a "care line," an after hours reporting and response system, in the Hartford area. After supporting this project for three years with State grant funds, the State has established the care line Statewide and is using Title XX funds and other sources to continue it.

necessary placement of children in foster care.

In North Carolina, we supported assignment of regional attorneys to provide training and technical assistance to child protective units on cases going to court, improving the capacity of the State to successfully petition courts for protective supervision of endangered children.

In Mississippi, we funded Statewide Child Abuse Hotline, now supported by State funds. We provided specialized child protective services workers in two counties which had no specialized workers previously, which resulted in a reduced caseload and faster return of some children to their families -- also now supported by State funds.

In South Carolina, we supported a project for military (Navy) families in Charleston, now continued with county and State funds, to provide an emergency crisis worker on 24-hour call. We supported a parent aide program in one county as a model for use in others. We supported Statewide technical assistance to church groups in organizing a preventive role. We initiated a State child abuse central register, now supported by State funds.

In Georgia, we helped initiate a law enforcement training effort on child abuse and neglect, which is now an integral part of law enforcement academies under the Georgia Peach Officers Council. Volunteer work has continued from two county Comprehensive Emergency Services projects initiated by the State grants program.

In Illinois, we supported development of a Statewide Central Register and System for receiving reports, together with TV public service announcements to inform the general public of the system which receives over 80,000 calls per year. Services of the Central unit and response system at local level were initiated or improved using State grant funds and now amount to a $45 million protective service program in the State.

In Michigan, we supported development of manuals, a client improvement measurement instrument used now by workers and effective in defining clients' propensity to reabuse or continue neglect of children. We piloted service models such as parent aide programs and tested materials developed, including organizational support for multidisciplinary teams, in preparation for submitting State legislation to make teams Statewide.

In Ohio, we supported an almost completed State computerized Central Register system. We tested and found successful an Ohio version of the Comprehensive Emergency Services system as a form of prevention of unnecessary placement of children in foster care, which will be fed into State Child Welfare Services Planning (under Title IV-B) in order to continue the system and expand it to other parts of the State.

In Minnesota, we initiated technical assistance for creation of multidisciplinary case consultation teams which are now in place in 54 of the State's 87 counties. We initiated training of public health nurses and pediatric nurse practitioners through the State Department of Health, which is being continued. We supported a prevention of child sexual abuse effort in the public school system.

In Arkansas, we initially funded the position of Administrator of Child Protective Services, a Statewide hotline, and a growth and development unit for child protective services, all of which have been continued with State funds.

In Oklahoma, we initiated a Statewide hotline, now supported by the State, and a State child protective services interagency committee, which still meets weekly. We developed and distributed a packet of child abuse and neglect materials at workshops and conferences. We supported medical examinations for abused children, now supported by State funds. And, we supported the development of a crisis service unit at Children's Memorial Hospital.

In Louisiana, we initiated and supported a State hotline, now supported by State. We supported four child protective service workers, one administrator, one homemaker, one attorney, one physician, and one psychologist (the latter three on contract) for multidisciplinary case consultation, all now supported completely by State funds.

In New Mexico, we developed a public and professional awareness program, with specific targeting of medical and educational systems, leading to increases in reports from these systems.

In Texas, we supported the development of CANRIS, a Statewide hotline and central referral system. We also supported development of the State's treatment capability, using counseling, therapy, homemaker services, family planning and medical care.

In Kansas, we originally funded the Kansas Home Visitor project as a pilot effort, contracted with the Kansas Department of Health and Environment. The project involved home visitors making a minimum of two contacts with mothers of all newborns in the project area. State legislation has continued this effort as a part of the Department's regular budget.

In Missouri, we supported the State Central Register development and implementation, which is now continued by the Division of Family Services with State funds.

In Nebraska, we assisted in the creation of the Omaha Council on Child Abuse and Neglect. The Council has been instrumental in developing a Comprehensive Emergency Services system and a public awareness program in the Omaha area. The Council is being continued with support from other sources.

In Utah, we initiated funding for the following services which have now been taken over by State support: 3 family support centers, 2 lay therapy programs, 2 sexual abuse treatment programs, 4 diagnostic multidisciplinary teams, 1 sexual abuse diagnostic team, 1 parent education program and the State's central register of reports of child abuse and neglect.

In Colorado, we supported the development of the State's Central Register of reports and an institute of community development in child protection to encourage and provide assistance in development of legislatively mandated multidisciplinary teams.

In Montana, we supported the creation and continuation of the State child protective services coordinator position.

In Puerto Rico, a Statewide, toll-free hot-line was funded to receive reports of suspected cases, 24-hours a day, seven days a week. The Department of Social Services has continued and expanded the unit with State funds. In addition, an emergency shelter for children was established.

In New Jersey, emergency imprest funds were made available to local offices to be used in cases of reported neglect in which the immediate need appeared to be economic crisis, resulting in a dramatic reduction in emergency foster care and leading to enactment of State legislation mandating continuation of the program and a revision of State public assistance policies regarding emergency assistance. We also developed a Protective Services Manual and Guidelines for workers and upgraded the State Central Register.

In New York, we provided technical assistance to develop multi-agency task forces at local levels, support for which has now been taken up by a private foundation with the view of creating a Statewide coalition of task forces.

We also supported New York City's Mayor's Task Force on Child Abuse and Neglect which was instrumental in developing the city's protective services system. We supported indepth study of child abuse and neglect case management in New York City, providing information which has been used by both city and State legislature. We supported development of a separate training institute for protective services in coordination with the Region II Child Abuse and Neglect Resource Center. We made possible the purchase of equipment to upgrade the State's central register system. We supported initiation of a Statewide Parents Anonymous hotline, which is now supported by a Title XX contract.

In the District of Columbia, we initially funded the FACT hotline, which has been subsequently supported entirely by the D.C. Department of Human Resources.

In Virginia, we supported a Statewide hotline and information system, now supported completely by State funds. A Statewide child protection newsletter was established with State grant funds and now is part of the budget of the Welfare Department.

In West Virginia, we funded a Comprehensive Emergency Services program in Charleston which has been continued with Title XX, HUD and private support.

In Alabama, we funded homemaker services in four pilot counties to prevent necessity for placement of children in foster care which program is now supported by State funds. Twenty-four hour tele-pagers and answering services were provided in 39 counties to allow for an around-the-clock response capability to reports.

In Tennessee, we supported a private family counseling agency to work with children placed outside of their own homes with the aim of reuniting families; a prevention program using trained volunteers and public health nurses for working with families at risk, and a program of psychological evaluation and treatment, using private teamsof psychologists as treatment resource and consultants and trainers for child protective services staff. All of these efforts are seen as developmental to improving the State's child welfare services system to increase its ability to prevent

In North Dakota, we supported the creation and continuation of the State child protective services coordinator position and initiated child abuse treatment programs at two sites in the State.

In South Dakota, we supported the creation and continuation of the State child protective services coordinator position, and a parent aide program.

In California, we supported the State Office of Child Abuse Prevention to serve as the central source of technical assistance to counties. This office has been instrumental in developing legislation for the 24-hour child protection response system, which was passed, and was then mandated to provide technical assistance to the Department in implementing the new 24-hour system. We supported a child sexual abuse prevention and treatment pilot program which the county has continued with local and State funds. We supported a number of pilot projects which have been continued and serve as models for other counties.

In Hawaii, we supported a public awareness effort resulting in pamphlets, films, tapes and a newsletter on the need for child protection in the State. The position created by the State grant has been continued with State funds. We supported intake aide positions to free protective services workers to perform investigative and treatment duties. These positions have since been continued with State funds.

Question: How much do States which receive these grants supplement the Federal payment?

Answer: There is no requirement in law or regulation that States match the Federal grants with any State funds. Some projects are supplemented with State funds, but there is no general rule which would describe their financial participation. It should be noted, however, that these funds are not used to fund direct services provided to clients, as in the case of Title XX and other social and child welfare services funds provided to State by the Federal Government or to duplicate or enlarge already existing services.

Question: Why can't States take over this responsibility without Federal aid?

Answer: There is nothing to prevent states from taking on the developmental, program start-up role which has been supported and stimulated. However, prior to the Child Abuse Prevention and Treatment Act of 1974 and the stimulus to State action provided by the Act, States' level of commitment to find ways to control and reduce the problem of child abuse and neglect was a mirror of the efforts then evident at the Federal level; that is to say, there was no such an effort at either State or Federal level.

The enactment of Federal legislation and the availability of at least some financial assistance to states has resulted in an increase in reporting of suspected cases of child abuse and neglect from approximately 140,000 reports in 1972 to 714,000 in 1980; and an increase in the number of States and jurisdictions that have strengthened their legislation and programs and procedures to handle child abuse and neglect from 3 in 1974 to 46 in 1980.

CHILD DAY CARE

A provision of the Reconciliation Act required the Department to assist States in assessing their practices with regard to Title XX day care programs and report back to Congress by June 1, 1981.

Question: What steps have you taken to fulfill this requirement?

Answer: The Department has offered various kinds of technical assistance to States to conduct this assessment. ACYF has awarded small grants to the States to help defray the costs of the assessment. The amount of the grant is based on the number of centers and homes in the State serving Title XX funded children. ACYF has developed and shared with the States a Technical Assistance Package including a suggested reporting form, a telephone survey for centers, a telephone survey for homes, sampling and compilation methods.

ACYF has conducted training sessions for State staff to advise them of the grant application process, introduce the Tenchical Assistance Package, and review the Department plans for preparation of a report. ACYF is providing on-site technical assistance to the States by Regional Office Day Care Specialists.

The Department plans to assess all reports received by April 15, prepare a summary report to be submitted with individual State reports, and submit this information to Congress by June 1, 1981.

Question: Are there certain States which have exemplary day care programs? Which are these?

Answer: Many States currently have exemplary day care practices, although these exemplary practices often are found in one area or the other, rather than across the board. For example, one State may have a superior caregiver training program while another has successfully linked day care programs to health services. Some States have and enforce licensing codes that could be regarded as model codes for ensuring the health, safety, and normal development of children. Most States are looking for ways to improve day care programs and for effective and cost-efficient methods of service delivery.

Question: What steps can be taken to encourage States to emulate the "model States"?

Answer: Sharing exemplary day care practices with all States is the best method of encouraging emulation. Most States desire to improve their day care programs in some way. At this time there is a particular emphasis on improved management. The Department currently supports research projects which gather, package, and disseminate best day care practices in the areas of management, licensing enforcement, parent involvement and caregiver training. These projects not only encourage emulation of best practices, they save shrinking State resources by avoiding duplication in the areas of planning and development and by identifying more effective and cost efficient methods of service delivery. Such research leading to technical assistance and transfer of model practices between States is an important function of the Federal Government in its attempt to work with States to improve the quality of day care programs and day care and related service delivery systems.

RUNAWAY YOUTH PROGRAM

Question: What changes in your funding pattern do you anticipate due to the new formula set forth in the legislation reauthorizing the Runaway Youth Program?

Answer: The impact of the new funding formula on the Runaway and Homeless Youth Program funding pattern will be substantial. As a result of the new formula, which requires that the amount of funds in each State be based upon their respective youth population under 18 years of age, 30 State jurisdictions will receive more financial assistance than in FY 1980, and 27 State jurisdictions will receive fewer funds. In some States, such as the District of Columbia, Vermont, Ohio, Florida, Indiana and Maryland, where the FY 1981 level is substantially below their previous year's level, existing grantees will have to seek supplemental support from other sources. Consequently, the total number of grantees in these States is likely to be reduced. It is also highly probable that funds will be redistributed within many State jurisdictions resulting in a decrease in the average amount of grant awards for each center within that jurisdiction. Prior experience dictates that some programs will be unable to continue providing the range of services existing in previous years, unless they can attract supplemental funds from other Federal and non-Federal sources. In some cases it is to be expected that this will severely hamper the ability of centers to adequately serve runaway and homeless youth and their families within their respective communities. This is particularly true of those grantees that rely heavily upon Federal funds. For those States experiencing major increases over FY 1980, such as Georgia, North Carolina, Virginia, Louisiana, Puerto Rico, Kansas, Illinois and Pennsylvania, new grantees will be funded and existing grantees will have an opportunity to expand their services.

Question: What changes in grantees will be made?

Answer: HHS anticipates fewer grantees in States where there have been substantial reductions in the level of Title III funds. In addition, there will be smaller grant awards to qualified applicants in States that will receive under $50,000 as mandated by the new formula.

It is anticipated that increased emphasis will be placed on developing networks of programs. Due to the funding constraints the new formula imposes on several State jurisdictions, those applicants which can demonstrate the provision of services through a consortium of related public and private nonprofit agencies may receive priority consideration. These "coordinated networks", have the potential to pool the resources of the respective agencies involved in order to provide needed services. This administrative configuration is favorable in that the financial burden to any member agency is lessened without a subsequent reduction in the quantity and quality of services rendered. Since runaway and homeless youth and their families require a range of counseling, referral, shelter, medical, and legal services, such coordinated networks are a viable means of maintaining quality services in spite of reductions in the direct share of Title III funds available.

Question: If changing over to this new funding allocation results in discontinuing certain projects, how will the decision be made as to which projects to discontinue?

Answer: Decisions concerning the continuation of runaway and homeless youth programs will be based entirely on the competitive grants application process. This process and the decision of who to fund is the responsibility of the 10 ACYF Regional offices. All applications, including those from both previously funded and new organizations will be subject to a competitive review and evaluation by one or more review panels. Competing applications will be assessed against a set of clearly delineated criteria and a score and ranking will be assigned to all applications relative to one another within a given State jurisdiction. The list of prospective grantees, along with the ranking determinations of the Grant Application Review Panel, will be sent to the Regional Program Director of ACYF who will make the final selection of grantees. The number of grants awarded within each State will depend upon the State's allocation under the formula and the number of acceptable applications.

Both current grantees and new applicants will be judged on the strength of their applications. While prior experience as a grantee is not a condition for granting an award, the statute requires that priority be given to organizations with prior experience in serving runaway and homeless youth and their families.

GROWING NUMBER OF "THROWAWAY" YOUNGSTERS

Question: What are the implications of the fact that an increasing number of runaways are really "throwaways" -- youngsters who have been thrown out of their homes by their parents?

Answer: The rise of "throwaway or homeless" youth has two primary implications. The first encompasses the broader issue of an increase in the number of families that are functioning poorly, thereby contributing to the growth of the homeless population. According to data appearing in the 1980 Senate Report on Homeless Youth, parents are increasingly more willing to abdicate their responsibility for their children and are more apt to rely upon social service systems to "parent" for them. These centers also report a substantial increase, not only in the number of such cases in the last three or four years, but in the severity of these cases as well.

While center staff are involving the parents of these "throwaway" youngsters in hopes of reuniting the family, they are generally finding the prospect of reconciliation unlikely. The parents of these children do not feel able or willing to invest the effort nececessary for restoring family unity. Quite often this is due to a combination of debilitating factors such as alcohol or drug abuse by the parents, physical, sexual, and emotional abuse of the young person, and a history of communication problems. In many of these cases, the magnitude of these problems does more than negate the ability of the parents to care effectively for their pushed out child, it also raises the possibility that a return to the home would significantly endanger the well being of the youth.

As a consequence of this phenomenon, there is an increasing number of homeless youth who are not receiving the range of positive experiences needed to help them become responsible adults.

In addition, there are negative implications of the growth of the homeless group for social service agencies. As indicated in the Senate Report, runaway centers are now finding it difficult to locate placements in foster care, group home care, or independent living under the auspicies of local social welfare agencies. The number of homeless and other youth in need of alternative living arrangements far exceeds the availability of slots. Foster parents are hard to locate and many State and local public and private non-profit agencies do not have funds to subsidize the independent living of mature homeless youth.

Question: Can these young people be restored to their families successfully?

Answer: It is unlikely that in the vast majority of cases, successful reunification with the parents will occur. Ten of eleven runaway and homeless youth centers surveyed in the preparation of the Senate Report on Homeless Youth claim that between 30 and 70 percent of the homeless youth they served were abused. The physical abuse ranged from incidents of being slapped and punched repeatedly to being threatened by parents with guns and knives. Reports of sexual abuse, molestation and rape by parents were not unusual. In addition, the 1978 evaluation of runaway youth programs included a study of 137 homeless youth interviewed three months after leaving the runaway youth program. Among these young people interviewed, 70 percent indicated that they were still unwilling or unable to return home. It is to be emphasized that homeless youth do not leave home to become adventuresome or because of slight misunderstandings within the family. Their parents actually push them out, or the young people leave to escape the consequences of devastating physical and emotional abuse.

Question: Should restoration to their families be a goal in providing services to throwaways?

Answer: Consistant with the goals of P.L. 96-509, the Runaway and Homeless Youth Act of 1980, every attempt should be made to restore the family unit. Resotration of the family is always preferable as long as there is a desire on the part of parents and the youngster to remain dedicated toward their reunification. Family reunification is a primary goal for the centers working with runaway youth. According to DHHS data, over 50 percent of the runaway population are able to be reunified with their respective families. However, given the extent of the maltreatment that the homeless youth population have received in their family, it is often not effective nor desirable to recommend that this client group be placed back into a dysfunctional family.

Both runaway and homeless youth are in need of a consistently supportive environment and adult figures that are positive role models. If a determination is made by parent, youth and center professional staff that reunification will provide further blocks to adolescent adjustment, then restoration should not be a prevailing goal.

Question: What alternatives are there to attempting to reunite throwaways with their families?

Answer: When all attempts to reunite the family have been exhausted, and restoration seems improbable, other alternatives must be excerised. These options fall into two broad categories: one involves providing the youth with a surrogate family which acts in place of the natural parents by providing a supportive emotional and physical environment. Foster care and temporary group home care are desirable placements in which either parent surrogates or a combination of adults and other youths of similar past experience provide the atmosphere necessary for positive adolescent adjustment. The other option, which is more successful with mature, responsible homeless youth capable of caring for most of their own needs, is independent living. These youngsters receive financial support and aftercare services which include counseling and employment services coordinated by an aftercare worker in a child welfare agency.

Other alternatives which are not conducive to the well being and safety of the homeless youth include temporary placements in detention faciliteis or returning the homeless youth to the street, where they often become the victims of substance abuse, child prostitution and pornography.

FAILURE TO TERMINATE BAD RUNAWAY YOUTH PROJECTS

A 1978 evaluation of the Runaway Youth Program, conducted by Berkeley Planning Associates, showed that several projects had uniformly poor ratings in almost all areas. Nevertheless, these projects continued to receive funding in Fiscal 1980.

Question: What are you doing to see that low performance projects are more promptly terminated in favor of better projects?

Answer: The National Evaluation of the Runaway Youth Program, conducted by Berkeley Associates, assessed a representative sample of 20 projects to determine the extent to which they had operationalized the four goals of the Runaway Youth Act as well as to measure the impact of the services they provided. The extent of goal implementation was determined by the degree to which the project provided the specific services and service procedures considered essential for meeting each legislative goal as well as the projects progress in achieving an overall well-functioning system. The client impact level was measured against a comprehensive set of evaluation standards which related to the service outcomes embodied in the legislative goals.

The evaluation did not find "that several projects had uniformly poor ratings in almost all areas." Rather, it found that:

Overall, the YDB-funded projects have successfully operationalized the four goals of the Runaway Youth Act and have implemented those services and service procedures identified as being essential to meeting the immediate needs of youth, resolving family problems, securing stable living arrangements for youth, and helping youth decide upon a future course of action. With the exception of outreach, aftercare, and follow-up services, the projects did not demonstrate any significant limitations in providing the full range of services most commonly required by the youth and families served.

These services include individual counseling, family counseling, group counseling, legal assistance, medical assistance, placement services, and general advocacy and support services. In addition to providing services directly to their clients, the projects also demonstrated solid working relationships with a number of key service providers in their local communities, including welfare departments, juvenile justice agencies, schools, and police.

To operationalize the goals of the Runaway Youth Act involved not only the provision of the services cited above, but also the establishment of a host of other organizational and management policies. The majority of the projects in the evaluation sample were found to have developed a set of written policy procedures; to have conducted formal staff performance reviews; to have implemented careful and thorough case management practices; to have established an open communication system among all staff members; and to have provided opportunities for youth to be involved in the development of their own service plans. In addition, staff at the sample projects generally demonstrated a high level of morale, with the projects experiencing limited degrees of unplanned staff turnover.

In terms of the effectiveness of the services provided, the evaluation found that the projects studied are "achieving substantial positive client impact levels."

Factors contributing to deficiencies in the service areas of outreach, aftercare, and follow-up were found to include political or philosophical considerations, for example, the need to maintain a low profile due to community resistance to a project for runaway youth or concern that the provision of long-term assistance would generate overdependency on the agency by former clients, as well as financial reasons. Given limited resources, some projects could not adequately address both the crisis and the aftercare needs of the young people and families they serve and, therefore, opted to focus primarily on the provision of crisis services.

The performance of the projects funded under the Runaway Youth Act are systematically monitored by the Regional Special Assistants for Youth Affairs and those programs that are found not to be functioning effectively are terminated.

Question: Are currently funded projects being systematically reviewed?

Answer: The Runaway Youth Act - funded projects are systematically reviewed by the Special Assistants for Youth Affairs, utilizing a number of different methods. First, each project is required to conduct an annual self-assessment of the extent to which it is in conformance with the Program Performance Standards established by the Youth Development Bureau, and to submit the findings from this self-assessment of their Regional Special Assistants for Youth Affairs. Additionally, each project is formally monitored by the SAYA once each funding cycle against the Program Performance Standards. These 13 standards relate to the basic program components enumerated in Section 315 of the Runaway and Homeless Youth Act as well as to the administrative requirements in the regulations. Eight of these standards relate to service components: outreach, individual intake process, temporary shelter, individual and group counseling, family counseling, service linkages, aftercare services, and case disposition. Five standards relate to administrative functions or activities: staffing and staff development, youth participation, individual client files, ongoing project planning, and board of directors/advisory body. As part of the self-assessment process, the projects are required to identify the specific actions that will be taken, either internally, by staff or through the receipt of expert consultation, to bring its procedures into conformance with the standards in each area in which a deficiency is noted. The implementation of these necessary actions are also monitored by the SAYAs, as is their progress in correcting deficient areas.

Additionally, each project has been required to submit an annual report as part of its non-competitive application for continued funding. These reports describe the organizational development of the program; provide an accounting of unmet service objectives; describe the services provided through coordinated efforts with other social services agencies; project program needs during the upcoming year; detail the non-Federal budget sources utilized; describe management and staff development initiatives as well as internal management practices and policies; discuss recurring problem areas related to administration and service delivery; and describe the use of training and technical assistance services, including anticipated T/TA needs. These reports are carefully reviewed by the SAYAs during the refunding process, and any questions generated by this review are discussed with the project staff.

Thirdly, each project is required, as a condition of funding, to submit a reporting form on each client receiving ongoing services as well as to submit a summary sheet indicating the number of youth served monthly on a one-time basis, either over the telephone or on a drop-in basis. Project conformance with these reporting requirements is monitored by the SAYAs, as is the number of young people being served. The latter monitoring is designed to review the extent to which each project is, in fact, serving the caseload projected in its funding application as well as to determine the continued need for services for runaway and homeless youth in the geographical area in which the project is located.

Question: Have these evaluations had any effect on subsequent funding decisions?

Answer: Yes. Once deficiencies in meeting Program Performance Standards (PPS) have been identified, it is the responsibility of the individual center to implement policies and procedures that will alleviate that deficiency. The fact that one or more PPS criteria have not been met is not a sufficient condition for terminating funding, since the intent of the PPS arc to stimulate the development of sound administrative practices and the rendering of needed services. However, the continued failure to remedy these deficiencies after they have been identified or the apparent inability to meet minimal acceptable levels of these standards has been a source of information which has impacted upon funding decision.

Conversely, those programs that are able to consistantly demonstrate the ability to conform to these standards provide evidence that Federal financial assistance should be continued for the duration of the grant period.

CHILD WELFARE TRAINING

Over the past few years a considerable sum has been appropriated for traineeships, teaching grants, grants to schools of social work.

Question: Since FY'77, how many teachers or social workers trained with these grants are currently working as professionals in the Child Welfare field?

Answer: The Child Welfare Services Teaching grants are awarded to accredited schools of social work to develop and strengthen educational programs related to child welfare. In FY 1978 we awarded 1,023 grants; in FY 1979 1,145; and in FY 1980 1,096. (Information is not available for FY 1977.) We do not know how many trainees are currently working as professionals in the child welfare field. However, the National Child Welfare Training Center is conducting a survey to collect information on the educational experience and employment patterns of recipientsof child welfare traineeships. Students receiving these training grants will be tracked for a five year period to determine the extent of their commitment to continued involvement in child welfare services. We will advise Congress of the results of this survey when it is completed.

Question: Does OHDS keep track of the work obtained by recipients of these grants?

Answer: OHDS is conducting a survey to track the work obtained by recipients of these grants. We do not now have any information on this.

For a number of years Congress has been trying to find out what need there was for further training of social workers, in the child welfare field and in other areas.

Question: What evidence is there that there exists a need for still more professionally trained child welfare workers?

Answer: Because child welfare workers with differing levels of education and experience are called upon to address the most serious social and personal problems of children and families, child welfare personnel need professional expertise in a variety of complex service areas including foster care, protective services, adoption, and family-based services designed to prevent dissolution of families. The complexity of these kinds of problems demands a level of professional expertise that is not uniformly available among child welfare staff. A national study of social services to children and their families conducted in 1977 revealed that only 25 percent of the 1.8 million children served by the child welfare system were being served by caseworkers with degrees in social work. Sixteen percent of these workers possessed bachelor degrees in social work and only nine percent held MSW degrees. The majority of cases (69 percent) were assigned to staff who lacked formal education in social work. We believe professional training is imperative to assure a satisfactory delivery of social services and we will continue to make efforts to increase the number of adequately trained workers serving children in need of child welfare services.

Question: What overlap is there between the 11 Child Welfare Services Training Centers and the 10 Child Abuse Regional Resource Centers funded under the Child Abuse Prevention and Treatment Act?

Answer: There is no overlap between the activities and functions of the Child Welfare Training Centers and the Child Abuse Regional Resource Centers. The Child Welfare Training Centers focus on: improving the education and qualifications of child welfare workers by improving curriculum in the schools of social work, and by developing and organizing teaching efforts related specifically to child welfare; and improving State child welfare programs by providing technical assistance and resource materials to help State agency staff address their particular service requirements, such as those mandated by the new Child Welfare Legislation. The centers also assist States in developing staff development plans and specific training activities.

In contrast, the Child Abuse and Neglect Resource Centers focus on providing technical assistance related specifically to protective services for child abuse and neglect. The Child Abuse and Neglect Resource Centers do not develop or disseminate materials related to other types of child welfare services. To the extent that they may require information on specialized training activities, they would look to the Child Welfare Training Centers and coordinate related efforts through the Regional training centers.

CHILD WELFARE SERVICES

The 1980 Adoption Assistance and Child Welfare Act formally linked Federal Child Welfare funds with AFDC Foster Care payments in an innovative way. This Act set forth a list of responsibilities states had to fulfill in regard to every child who was in foster care. Each state would receive incentive payments for removing children from foster care and either reuniting them with their families or finding them a new permanent home. In addition, AFDC Foster Care payments, which previously had been an open-ended entitlement, were capped to further encourage states to remove children from foster care.

Question: What plans does the new Administration have for this program?

Answer: This matter is currently under review by Secretary Schweiker. Once the new Administrations policy has been established, it will be provided to the Subcommittee.

In order to comply with the Adoption Assistance and Child Welfare Act, States have certain responsibilities: among these, to conduct an inventory of all children who are in foster care for at least six months, to periodically review the cases of all foster care children, and to prepare a written plan for each foster care child to place him or her in a new home.

Question: What progress is being made in meeting these objectives?

Answer: During FY 1980, the Department reestablished the joint State/Federal child welfare planning process. This voluntary partnership led to the development of the FY 1981 State child welfare services plans that were developed and submitted by 40 States. This joint planning process, now a requirement under P.L. 96-272 (Sec. 422), is assisting States in establishing quantifiable goals and objectives that directly relate to the purposes of P.L. 96-272, namely, reducing the inapproriate separation of children from their homes; increasing the number of legally free, special needs children, who are adopted; and, reducing the average length of stay of children in foster care. The joint planning process will also assist States in initiating and maintaining those elements of P.L. 96-272 that are required for receipt of the additional Federal payments under Sec. 427(a), for example, the inventory of children in foster care and the case review process which includes a written plan for each child as specified in Sec. 475 (1).

Question: Which States have already met these goals?

Answer: Sec. 427(a) of P.L. 96-272 establishes the requirements for an inventory of all children in foster care for at least six months and a case review system which includes a written plan for each child in foster care as defined in Sec. 475 (1). Information as to the specific States that qualify for the additional Federal payments under this section of the law is unavailable at this time. The Act was signed into law on June 17, 1980. A notice of proposed rulemaking was published on December 31, 1980. The public comments will be analyzed and final rules will be prepared. The final rules will provide the basis for determining eligibility for funds under Sec. 427(a).

Question: How many children does the Department estimate are in Foster Care nationwide? How accurate is this figure?

Answer: During the past decade there has been no national reporting of children receiving child welfare services. Detailed data exists for a fifteen year period from 1956 to 1970. To fill in the gap, the Children's Bureau conducted a national study based on a probability sample to estimate the number of children in foster care, their characteristics, problems, services provided, and qualifications of the caseworkers who work with the children and families.

The survey was conducted during the first three months of calendar year 1977. At that time there were 395,000 children in foster family homes; 12,000 children in public group homes; 23,000 children in private group homes; 29,000 children in residential treatment centers; 21,000 children in public child-care institutions; and 22,000 children in private child-care institutions. This represents an increase of 184 percent since 1961. During the same time the population less than 18 years increased by only 4 percent.

The final child sample size was 9,597, for a response rate of 89 percent. At the 95 percent confidence level the real, but unknown, numbers may differ from the sample estimates by as much as plus or minus 15,000 children in foster family homes, 3,000 children in group homes, and 4,000 children in institutions.

Question: How many states already have an accurate "inventory" of the number of children in Foster Care? Which are these States?

Answer: As mentioned earlier, forty-five States have conducted an inventory. It is assumed that, at a minimum, the inventory contains the number of children in foster care. However, this may include children who have been in foster care less than six months as well as those in care six months or more.

A $220 million supplemental is being sought in FY'81 as an advance appropriation for FY'82, as authorized by law.

Question: What progress has been made to date in implementing P.L. 96-272, the Adoption Assistance and Child Welfare Act, which was fully funded under the Continuing Resolution?

Answer: P.L. 96-272 was signed into law by the President on June 17, 1980. The new law created a significantly redesigned foster care maintenance program in Title IV-E, a new adoption assistance program, and made major improvements in the IV-B Child Welfare Services program. The legislation required that ACYF create and operationalize a major new program by early FY 1981 in order to assure that the flow of foster care maintenance money to the States would not be interrupted. To accomplish this on a very fast track, ACYF prepared an interim State Plan preprint to be completed by States requesting money under Title IV-E, developed necessary fiscal forms, amended the existing IV-A State Plan to comply with the new law, prepared documents necessary to transfer formally the IV-A foster care program to ACYF, and prepared and discussed with each State its funding allotment. To prepare the States and Federal Regional Offices for the new role created for ACYF by P.L. 96-272, ACYF conducted training sessions with each State; and trained the staff in its 10 Regional Offices in the goals of the new law, the responsibilities of their respective offices, and the mechanics of implementing the new IV-E program and assuming responsibility for the existing IV-A foster care program. ACYF has successfully accomplished these tasks in less than eight months.

Concurrently, ACYF prepared the proposed regulation governing P.L. 96-272. The proposed regulation, published on December 31, 1980, was also completed on a very fast track, in half the usual time for preparing a proposed rule for major regulations. The regulation sets forth the proposed requirements for Title IV-E, Title IV-B, and the adoption assistance programs. During January 1981 the Department held 10 Regional hearings to discuss the proposed regulation. In addition to the hearings, ACYF is currently receiving written comments on the proposed regulation. The comment period will end March 16, 1981. ACYF will be carefully analyzing the comments preparatory to drafting its recommendations for the final regulation.

Question: Further, what steps has the Department taken in specific response to the growing concern about the costs of developing, promulgating, and implementing regulations for P.L. 96-272?

Answer: The Department is vitally concerned with the costs attendant to developing and implementing new regulations. Regarding P.L. 96-272, we have taken several steps. We have undertaken a full airing and analysis of the proposed regulation which was published on December 31, 1981. In addition to the 10 Regional hearings already completed, the Department will be carefully analyzing all comments received during the 75 day public comment period which ends March 16, 1981. These comments will be closely scrutinized for information relevant to the cost and burden of the proposed regulation. In addition, the Department prepared a Regulatory Analysis Threshold Study prior to publishing the proposed rule. The Threshold Study analyzed the cost implications of the proposed regulation.

In preparing the proposed regulation and in implementing the foster care maintenance program under Title IV-E, the Department has been in close communication with State Agencies, private providers, advocacy organizations and our own Regional Offices. The Department will carefully weigh the information we continue to collect through this process.

In addition, the Department will be preparing a Regulatory Impact Analysis of the final regulation. This will be completed consistent with the requirements contained in Presidential Executive Order 12291. We believe the Regulatory Impact Analysis to be an important document that will affect policy decisions on issues emanating from the public participation process and the analysis of the proposed regulation.

In the preamble to the proposed rule, we indicated that cost consequences were carefully considered in drafting the regulatory provisions, that the law and regulation contemplate moving children out of prolonged and costly foster care arrangements into permanent homes. The Department remains sensitive to the intent of this landmark new law and will prepare a final regulation that is cognizant of the growing concern with costly regulation.

MODEL STATE ADOPTION ACT

Last year on February 15, HHS published in the Federal Register a Model State Adoption Act. This model law was extremely controversial, and the Committee understands that over 8,000 comments were received on it.

Question: What is the status of this model act?

Answer: The Model Adoption Legislation and Procedures Advisory Panel, required by P.L 95-266 was established in August 1978. It met nine times for a total of 27 days

In October 1979 the Panel submitted its recommendations to the Secretary of HHS. The Secretary decided to publish the Panel's recommendations for public comment. In February 1980 the proposed Model State Adoption Act and Model State Adoption Procedures were published for a comment period of 120 days. During this comment period the Department held ten regional meetings to elicit more extensive, in-depth, comments and discussion. Following this the Department completed an analysis of the public comments, and identified several particularly controversial issues. Consideration has been given to various options and the matter is currently under review by Secretary Schweiker.

Question: Does the Department intend to issue a final version of this act? Why?

Answer: This matter is currently under review by Secretary Schweiker.

The Child Abuse Prevention and Treatment and Adoption Reform Act of 1978 (P.L. 95-266) detailed four program areas for the adoption opportunities program to explore: (1) development and dissemination of a model state adoption act; (2) development and implementation of a national adoption and foster care data-gathering system; (3) development of a national adoption information exchange system; and (4) development of an adoption training and technical assistance program.

Question: What progress has been made in the development and dissemination of a Model State Adoption Act?

Answer: The Model Adoption Legislation and Procedures Advisory Panel, required by P.L. 95-266 was established in August 1978. It met nine times for a total of 27 days.

In October 1979 the Panel submitted its recommendations to the Secretary of HHS. The Secretary decided to publish the Panel's recommendations for public comment. In February 1980 the proposed Model State Adoption Act and Model State Adoption Procedures were published for a comment period of 120 days. During this comment period the Department held ten regional meetings to elicit more extensive, in-depth, comments and discussion. Following this the Department completed an analysis of the public comments, and identified several particularly controversial issues. Consideration has been given to various options and the matter is currently under review by Secretary Schweiker.

Question: What progress has been made in the development and implementation of a National Adoption and Foster Care Data Gathering System.

Answer: A national reporting system has been developed, tested in eight States and has been sent forward for OMB clearance. The content of the reports to be generated by the States has been negotiated with the participation of representatives from each State child welfare service, a panel of APWA (State Administrators) and other national groups. The entire process has been carried out with States' participation to maximize consensus in developing a viable and useful set of reports.

National data will be collected as of FY 1981 on children in voluntary placement as mandated in P.L. 96-272. Information on all other children in foster care or receiving adoption services will be reported beginning in FY 1982. Reports on voluntary placement agreements will be available by December 31, 1981 and reports for all children receiving foster care or adoption services will be available by March 31, 1983. Information to be collected will include descriptive items such as demographic data, family structure, legal custody status. Characteristics of foster care include reasons for placement, length of time, number of placements per child. Information on children free for adoption includes items for the number adopted, with or without subsidy, number of special needs children, and length of time awaiting adoption.

Question: What progress has been made in the development of a National Adoption Information Exchange.

Answer: The Department developed a project to make use of the expertise of the Child Welfare League of America to help develop a

National network of exhanges, including the direct operation of a National adoption exchange. The project provides training and technical assistance to States and regions in establishing new exchanges and improving existing exchanges.

The purpose of this network of exchanges is to facilitate the adoption of special needs children who would benefit by a wider geographic search for families, using such services as registration and photo-listing. The National Adoption Exchange operated by the Child Welfare League of America demonstrates that through national exposure, adoptive families can be found when exchange resources have been exhausted on a local or regional level. In collaboration with the Regional Adoption Resource Center, technical assistance has been provided to 49 of the 50 States, in the form of workshops, training and problem solving consultation. Existing State and regional exchanges have been strengthened and new ones established. For example: in Region IV, only 3 of 8 States in that region had adoption exchanges. With the technical assistance provided from the Adoption Resource Center, all 8 States now have an operating adoption exchange.

The Adoption Resource Centers (ARC) are also planning for a regional exchange in each of the ten DHHS Regions. These planning activities included developing strategies to obtain financial support from the States to establish and continue regional adoption exchanges.

The Region X ARC provided extensive training and technical assistance to the Northwest Adoption Exchange (NWAE) in obtaining contracts with the States in that region. Prior to the Center's involvement not one State had agreed to contract for the Exchange's services, now all four States in Region X (Alaska, Washington, Oregon, Idaho) and two States in Region VIII (Montana and Utah) have agreed to contract with the NWAE.

Question: What progress has been made in the development of an Adoption Training and Technical Assistance Program?

Answer: The Children's Bureau, ACYF, has funded an Adoption Resource Center in each of the ten DHHS Regions to provide extensive support to States to improve their adoption services to children with special needs.

The Resource Centers have established working relationships with public and voluntary agencies and adoptive parent groups. The Centers have identified program and training needs on special needs adoption; gathered data on the number of children in care; disseminated information on a variety of adoption issues; conducted workshops and provided training and technical assistance to help public and private adoption agencies in the States to accomplish specific objectives. For Example:

The Region VI ARC assisted Louisiana and New Mexico regarding the revision of a data collection system for the number of children in care.

The Region I ARC assisted the New Hampshire State agency to develop a methodology for a unit cost study of adoption programs to demonstrate the cost-effectiveness of adoption services.

The Region IV ARC assisted the Mississippi Department of Public Welfare regarding the recruitment of adoptive families.

Region VIII ARC assisted the Colorado State Department of Social Services on legislation implementing adoption subsidy.

Region VIII ARC assisted the Wyoming State Department of Social Services on legislation implementing adoption subsidy.

Region III ARC assisted a West Virginia State agency to develop an information system to provide a geographic profile of waiting children and adoption services.

Region I ARC assisted the Exchange Directors in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut on contracting and purchase of services between public and private agencies for adoption services.

Region X ARC assisted Oregon regarding administrative support for special needs adoption programs and technical assistance on the purchase of service contracts.

Region X ARC assisted Alaska on adoption exchange models in order to assist Alaska to develop a statewide exchange.

Region III ARC assisted private agencies in Pennsylvania to conduct recruitment compaigns for adoptive parents.

Region IV ARC assisted caseworkers and supervisors of the Children's Home Society of Florida on family assessment.

Region IV ARC assisted South Carolina adoption agencies on the use of photo-listing as a recruitment tool.

Region VIII ARC assisted the Sisseton-Waupeton Sioux Tribe in (South Dakota) on the provision of child welfare services and assistance to the South Dakota State agency to develop a State adoption exchange and training network.

Region VIII ARC assisted North Dakota adoption agencies to provide adoption services to potential adoptive families for out-of-State children.

Region V ARC assisted 120 staff members of Wisconsin adoption agencies on a variety of adoption issues including recruiting adoptive homes; preparing the older child for placement;and purchase of service contracts.

Region IX ARC assisted a private agency in Hawaii to form an adoptive parent group.

Region I ARC assisted the Connecticut Adoption Resource Exchange (CARE) to improve exchange data flow.

Region VI ARC assisted a Missouri State agency on improving a State adoption exchange and Missouri public and voluntary agencies on recruitment of adoptive families.

In addition to the work of the ARCs other projects have been funded to provide additional resources such as model service delay approach and technical assistance. These include: Radio and TV Public Service announcements which have been developed to encourage adoption of special needs children and are now being disseminated by the ARCs; a 45 hour adoption training curriculum has been developed and is ready for field testing in May and June, 1981; a Partnership for Permanence Project is in its second year of operation and provides child advocacy seminars, newsletters and cooperative work between adoption agencies and adoptive parent groups in locating and utilizing adoptive families for special needs children; utilization of the Interstate Compact on the Placement of Children to enhance the opportunities for placement of special needs children across State lines for adoption when such placements are appropriate; establishment of a national center for Homes for Black Children to provide intensive specialized adoption training to a select group of agency leaders and/or workers in six different urban areas to meet the needs of black children in adoption and provide a model for such agencies; an Hispanic Adoption Project to provide a model of services to Hispanic children in the New York Metropolitan area; and a project led by the New York Chapter of the National Association of Black Social Workers, to demonstrate methods by which black families can be more effectively recruited for black children, leading to their more timely placement.

Question: How will activities in this program be coordinated with the new adoption subsidy program and State inventories mandated by the Adoption Assistance and Child Welfare Act of 1980?

Answer: The activities authorized by Adoption Opportunities Program provide leadership in the development of materials and projects that will support the achievement of the goals of P.L. 96-272.

Both programs complement each other in achieving permanent adoptive families for special needs children. The adoption assistance (subsidy) program provides federal funding to States for the adoption of eligible special needs children. However, the adoption opportunities program provides models, technical assistance and training to State and voluntary agencies that is needed for placement of these children in permanent adoptive families. Examples of the training and technical assistance provided are curriculum training that focuses on the skills involved in preparing families and children for adoption; utilization of the Interstate Compact on the placement of children to enhance the opportunities for placement of special needs children across State lines; & recruitment of adoptive and foster families through radio and television public service announcements.

The State inventories mandated by the Adoption Assistance and Child Welfare Act will provide for each State a listing of all children in foster care for 6 or more months. It will also provide, through the development and implementation of realistic case plans, for the identification of those children who are free for adoption and those who should be freed for adoption services.

Through its national projects which place emphasis on the adoptive placement of children with special needs, the Adoption Opportunities Program provides the technical assistance to States so that they can effectively implement these goals.

Question: Isn't the Adoption Opportunities Program duplicative of most of the provisions of the much broader Child Welfare Act? If not, why not?

Answer: No. The Adoption Opportunities program is a discretionary grant program which authorizes the development of various products and activities useful to the accomplishment of the goals of P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980. It must be noted that P.L. 96-272 is a State formula grant program which provides federal funds to States to offset the costs of adoption assistance and foster care maintenance payments in addition to child welfare services. P.L. 96-272 does not provide any funds for developmental purposes or technical assistance, such as, the National Adoption Information Exchange, adoptive and foster parent recruitment materials and programs, training initiative and so forth. Thus the Adoption Opportunities program is discretionary and its focus is on eliminating barriers to the adoption of special needs children while P.L. 96-272 is a State formula grant program providing funds to States for maintaining assistance and social service programs. Adoption opportunities activities complement the ongoing activities of P.L. 96-272.

ADOPTION ASSISTANCE - SPECIAL NEEDS

The New Adoption Assistance Program provides federally matched funds for payments to parents who adopt children with "special needs." Special need children are those with special handicaps or medical conditions, or who are members of a particular minority or ethnic group, and as a result of this condition the child is difficult to place in an adoptive home.

Question: How many "special needs" children are there in the US available for adoption?

Answer: Our best estimate is that there are about 30,000 to 40,000 children with special needs free for adoption.

Question: How many children do you estimate may be adopted as the result of this provision?

Answer: Our best estimate is that approximately 3,000 children will be adopted with Federal financial participation (FFP) under this program in FY 1981. There are two considerations that affect this number.

First, this program provides adoption assistance only for children for whom the Federal Government might have participated in paying foster care. Only about twenty percent (20%) of foster care children receive AFDC-FC. Similarly, we expect the Federal adoption assistance program to reach only a limited proportion of children receiving such assistance from States. States will remain responsible for the other children without Federal financial participation.

Second, many States are still in the developmental stage of deciding when to operate under a Title IV-E plan. Adoption assistance is not available to States operating foster care under the Title IV-E program in FY 1981 and therefore receive FFP in adoption assistance this year.

Question: What do you anticipate would be an average monthly payment to an adoptive parent under the program?

Answer: We estimate an average adoption assistance payment of $323 per month during FY 1981.

[CLERK'S NOTE.—The following is the administration's response to those questions in the record that were under review by the Secretary at the time the Department submitted earlier responses.]

OHDS - Child Welfare

Senator Inouye: What impact would the consolidation of Title IV-B, Child Welfare Services, into a Social/Community Services Consolidation, have on special services to Native American groups?

Answer: The Office of Human Development Services, has not made a final decision on that question. We need to further address what kind of impact the Social/Community Services would have on Native American groups as we continue to examine the block grant issue.

ACYF RESEARCH AND EVALUATION ACTIVITIES

The following description of the current research areas of ACYF summarizes the agency's efforts in its research, demonstration and evaluation programs over the past several years. The areas identified should not be viewed as discrete functions within the agency but rather as a method of organizing related projects. Many of the projects are in fact cross-cutting in their concerns and are coordinated within different parts of the agency. Because all of the projects relate in some way to children, youth and families, findings in one area are often used to improve programs in other areas.

Head Start research, demonstration, and evaluation activities are intended to strengthen Project Head Start as a national program providing community-based developmental child care to low-income children. More specifically, this entails improving the quality and delivery of local Head Start services in the areas of education, health (including medical, dental, mental health, and nutrition), parent involvement, and social services.

Child Welfare research, demonstration, and evaluation activities are intended to improve the quality and increase the availability of child welfare services to children and their families by assisting public and private child welfare agencies to enhance the overall child welfare delivery system and to improve specific services and components of the system which impinge directly on children and their families. These latter encompass the following: reduce the dysfunction in and provide support to families in order to prevent separation of children from their families; restore children to their families, or, if that is impossible or inappropriate, place them permanently, in adoption or permanent foster care; and improve the quality and availability of foster care services for those children who must be separated from their families and who must be served by the foster care subsystem for some period of time.

Of course, improvements to the overall child welfare system will also improve the specific services and components.

Child Abuse and Neglect research, demonstration, and evaluation activities are intended to improve the prevention, identification, and treatment of child abuse and neglect by assisting and enhancing national, state, local, community and citizen efforts.

Day Care research and demonstration activities are intended to improve the quality and expand the availability of day care services provided to children and their families. Specifically, ACYF efforts focus on: conducting applied research bearing upon national day care policy issues; developing and testing program models; providing technical assistance to State and local government agencies, other organizations, and individuals in such areas which include the provision of day care services and the monitoring and enforcement of licensing regulations; providing leadership in the development and assessment of Federal day care standards and requirements; and planning and implementing the day care provisions of Title V, Part D, of the Head Start, Economic Opportunity, and Community Partnership Act of 1974 (P.L. 93-644).

Child and Family Development research activities are intended to better rationalize Federal and non-governmental service and benefit systems aimed at improving child and family development (within projected Federal expenditures for children) by: developing national policy on child and family development, including determination of factors which best promote such developments, selection of appropriate measures, and evaluation of alternative intervention strategies; establishing an information capability to maintain a systematic process for determining and reporting on the status of children and of services to children and families, and for conducting target group analyses to define the most appropriate relationships between various programs and services; and developing effective mechanisms to to bring about needed policy changes and to effect coordination to achieve common objectives related to the needs of children.

Youth research, demonstration, and evaluation activities are intended to enhance the capacity of public and private agencies to meet the immediate and long term needs of runaway youth and their families; and to develop and implement strategies for institutional change designed to promote the optimal development of vulnerable youth.

AGING RESEARCH AND DEMONSTRATION PROGRAMS

Aging Research and Demstration Activities are authorized by Title IV, Parts B and C of the Older Americans Act.

The aging research and development program seeks: (1) expansion of knowledge as to the obstacles to the development of local comprehensive and coordinated service delivery systems which meet the special needs of older persons, and techniques for overcoming the obstacles; and (2) policy oriented research to assist other Federal agencies to move toward accomplishment of the objectives set forth in Title I of the Act.

Discretionary Projects and Programs serve as an important resource to supplementing and expanding social services provided under Title III of the Older Americans Act. The aim is to improve or expand services in order to provide additional services to those elderly persons with unique problems which require innovative approaches. These projects: contribute to our continuing search for improved management and the efficient use of scarce resources enabling the aging network to identify improved solutions to new and emerging problems; and are the testing ground for the development of services to address emerging social problems which are being inadequately resolved by existing service programs.

Question: What program evaluation projects are planned for Fiscal Year 1982?

The following evaluations initiated in prior years will remain active in Fiscal Year 1982:

Longitudinal Evaluation of the Nutrition Program for the Elderly

Rural areas and Small Communities Recreation Assessment (with The Department of Interior)

HUD Congregate Housing Evaluation (with The Department of Housing and Urban Development)

Evaluation of Long-Term Care Channeling Demonstrations

Evaluation of Title VI Grants for Indian Tribes

Strategy Evaluation for the Provision of Training and Technical Assistance.

Evaluation of State Education and Training

Assessment of the Adequacy of In-Home Services

Assessment of the Adequacy of Adult Day Care and Related Services

In addition to the evaluations described earlier, the above list includes the following evaluations:

o Rural Areas and Small Communities Assessment: The overall objectives of this assessment are to: determine the recreation, cultural, and open space needs of rural residents; develop positive Federal policy directions to expand the delivery of recreation services in rural States and communities; and focus attention on the unmet recreation needs of special rural populations, such as the aging.

o Evaluation of Grants to Indian Tribes for Social and Nutritional Services: Determine to what extent essential components of the Title VI program have been implemented; develop a typology of projects which can serve as the basis for comparative analysis; obtain information on obstacles to full operation of the Title VI program; ascertain factors which differentiate projects which have operational programs from those which have been plagued with problems; improve AoA's planning and policy-making capabilities with regard to Title VI through study and analysis of projects, their variations, the factors related to their variations, and types of resourcefulness in service delivery and management undertaken to achieve Title VI program goals; and review, analyze, and improve the Title VI reporting system, including management approaches to data collection.

Strategy Evaluation for the Provision of Training and Technical Assistance: This project will evaluate alternative methods of providing training and technical assistance to the network of agencies serving older people. It will investigate and compare alternate strategies for the use of a wide range of advance techniques and technologies available or becoming available for the interactive transmission of information.

o Evaluation of State Education and Training Program: The Purpose of this study is to conduct a program performance evaluation of the State Education and Trainiing Program authorized under Title IV-A of the Older Americans Act. Results obtained from the evaluation study will be of use to administrators, policy-makers, and program managers who are concerned with providing education and training to staff of State and Area Agencies on Aging, and other personnel who are responsible for providing services to the elderly population throughout the United States. The objectives of this study are as follows: to provide, in a systematic fashion, successive increments of information on the State Education and Training Program potential and program performance; to define the State Education and Training Program activities, objectives, its managers' and policy-makers' information needs and priorities, and determine how the program is performing in terms of agreed-upon objectives and performance indicators; and to provide alternative designs for performance evaluation if the program performance information collected during this study indicate that additional information is needed and is likely to be useful.

Assessment of the Adequacy of In-Home Services: This project will identify providers and the in-home services currently being provided to the elderly and disabled, will develop criteria for determining the adequacy of these services, and will (on a selective basis) assess the adequacy of services currently being provided.

o Assessment of The Adequacy of Adult Day Care and Related Services: The purpose of this procurement is to develop guideline criteria for assessing the adequacy of adult day care and related services in meeting the needs of the elderly. The criterial will be pilot tested and the results will be used by providers to perform self-assessment. The project will provide: (a) A systematic collection of information on adult care and related services. (b) A basis for assessing the adequacy of adult day care. It is anticipated that more than two models with different goals and services will be identified. Cost factors can then be considered in relation to the types of services which are offered. The information derived from this study will form a basis for developing guideline criteria for assessing the adequacy of adult day care and related services which are currently being provided. Results from this project can be used by program managers and policy makers to determine when and under what conditions the identified services best meet client needs and which client groups are most appropriately served by this cluster of services.

New evaluation initiatives for Fiscal Year 1982 are now being developed. Attention is focussing on those efforts that will contribute to the development of comprehensive and coordinated community services systems under Title III of the Act. This will likely include projects aimed at enhancing the capacity of State and area agencies to carry out the evaluation responsibilities assigned them by Title III of the Act, producing policy evaluation studies in areas of substantive concern to older persons, for example, housing, and producing information for decision makers at the Federal, State and local levels related to specific areas of services provision.

MODEL STATE ADOPTION ACT

Last year on February 15, HHS published in the Federal Register a Model State Adoption Act. This model law was extremely controversial, and the Committee understands that over 8,000 comments were received on it.

Question: Does the Department intend to issue a final version of this act? Why?

Answer: The Department intends to issue a final version of this act which deals solely with the adoption of children with special needs who, because of ethnic background, age, membership in a minority or sibling group, medical condition(s) or physical, mental, or emotional handicap are hard to place in an adoptive home.

There has been broad support for the development and publication of an act that would facilitate the adoptive placement of such children and the Department intends to issue such an act in the near future.

Question: As more states come into compliance and as reported incendents of abuse increase, will an increasing proportion of funds be spent on grants to states ?

Answer: After FY - 81, the state grant portion of the Child Abuse and Neglect Program will be included in the proposed Social Services Block Grant.

CHILD WELFARE SERVICES

The 1980 Adoption Assistance and Child Welfare Act formally linked Federal Child Welfare funds with AFDC Foster Care payments in an innovative way. This Act set forth a list of responsibilities states had to fulfill in regard to every child who was in foster care. Each state would receive incentive payments for removing children from foster care and either reuniting them with their families or finding them a new permanent home. In addition, AFDC Foster Care payments, which previously had been an open-ended entitlement, were capped to further encourage states to remove children from foster care.

Question: What plans does the new Administration have for this program?

Answer: This program is one of those proposed for consolidation into the Social Services block grant. The proposed Social Services block grant includes language to repeal authorizing legislation for this program.

CHILD DAY CARE REGULATIONS

In the first Continuing Resolution passed last year and in the Reconciliation Act, Congress delayed the date for implementing the new Federal Day Care Regulations until at least July 1, 1981. Many members feared that these regulations were very costly and might reduce the quantity of day care services available to working parents.

Question: What is the new Administration's view of these regulations?

Answer: The new Administration will examine the Federal Day Care Regulations in light of the proposed Social Services block grant. At this time, the Department is assisting the states in carrying out an assessment of their Title XX day care practices, and will consider the results of those assessments in determining the need for regulations in this area.

SUBCOMMITTEE RECESS

Senator INOUYE. Thank you very much. We will recess the subcommittee until 9:30 a.m., March 6, when we will hear testimony from the Department of Education.

[Whereupon, at 12 Noon, Friday, February 27, the subcommittee was recessed, to reconvene at 9:30 a.m., March 6.]

[CLERK'S NOTE.—The March 6. 1981 testimony on appropriation requests for the Social Security Administration and Office of Refugee Resettlement will follow.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

FRIDAY, MARCH 6, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:10 a.m. in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Lawton Chiles presiding.

Present: Senator Chiles.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF HERBERT R. DOGGETTE, JR., ACTING COMMISSIONER OF SOCIAL SECURITY

ACCOMPANIED BY:

- **ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET**
- **LOUIS B. HAYS, ACTING DIRECTOR, OFFICE OF CHILD SUPPORT ENFORCEMENT**
- **LAWRENCE H. THOMPSON, ASSOCIATE COMMISSIONER FOR POLICY**
- **IRA GOLDSTEIN, ACTING ASSOCIATE COMMISSIONER FOR FAMILY ASSISTANCE**
- **SHERWIN T. MONTELL, DIRECTOR, OFFICE OF FINANCIAL RESOURCES**

SUBCOMMITTEE PROCEDURE

Senator CHILES. Good morning. The subcommittee will come to order.

This morning we are going to hear testimony on the budgets for the Social Security Administration and the Office of Refugee Resettlement. We will begin with testimony for the Social Security Administration.

This subcommittee does not appropriate the entire budget for this agency since regular social security and disability insurance benefits are paid out of the trust funds. The subcommittee, however, does have oversight over Social Security Administration and does directly appropriate for supplemental security income and assistance payments.

Here to testify is Mr. Herbert Doggette, the Acting Commissioner of Social Security. We are glad to have you here and if you would please present the other people you have with you.

INTRODUCTION OF ASSOCIATES

Mr. DOGGETTE. Thank you very much, Mr. Chairman. I'd like to introduce starting at my extreme right, Mr. Ira Goldstein, who is the Acting Associate Commissioner for the Office of Family Assistance. Next to Mr. Goldstein is Mr. Lou Hays, who is the Acting Director of the Office of Child Support Enforcement. On my left is Mr. Larry Thompson, the Associate Commissioner for the Office of Policy. Next to Mr. Thompson is Mr. Sherwin Montell, the Director of the Office of Financial Resources in the Social Security Administration; and at my extreme left is Mr. Tony Itteilag, Acting Deputy Assistant Secretary, Budget, in the Department of Health and Human Services.

Senator CHILES. All right, sir. If you could proceed with your overview statement, your full statement will be inserted in the record, and if you could brief that for us we would appreciate it.

PROGRAM OVERVIEW

Mr. DOGGETTE. Thank you very much, Mr. Chairman. What I would propose to do, with your permission, is to quickly run through a set of overview program charts which explain the programs that we administer in some detail.

Mr. Chairman, recognizing your knowledge of the social security program, I will go through these rather quickly.

Senator CHILES. Don't recognize anything.

Mr. DOGGETTE. I'll cover the first items down through this one and the Acting Director of the Office of Child Support Enforcement, Mr. Lou Hays, will cover the last item.

OLD-AGE SURVIVORS AND DISABILITY INSURANCE (OASDI) BENEFITS

The summary chart lists the basic programs that we administer in the Social Security Administration and the first major program I'd like to talk about is the old-age and survivors insurance program. The basic idea of this program, which we refer to as the OASDI program, old-age survivors and disability program, is to provide cash benefits to eligible persons to replace earnings lost because of retirement, disability, or death.

The concept of the program is that individuals while they are earning money pay into the social security trust funds through the mechanism of the FICA tax, the Federal Insurance Contribution Act tax. The employees, employers, and self-employed pay this tax through contributions on payroll. That money is retained in the trust funds and when these individuals or eligible dependents either retire, become disabled, or a death occurs, cash benefits are paid to the workers and/or their dependents.

The basic principles of this program are that it is a work-related program. It involves an earned right. That is, there's a tax paid into the program. Those persons who do not pay a tax into the program are generally not eligible to receive benefits from the program. There is no means test for any of the benefits. It is a contributory system based on the tax contribution, with very few limited exceptions. It is also a compulsory system with roughly 9 out of 10 Americans covered under this program on a compulsory basis.

SUPPLEMENTAL SECURITY INCOME

The second program I'd like to talk about is the supplemental security income program. This program provides cash payments from general revenues for certain categories of the aged, the blind, and the disabled. It supplements income that these categories of individuals have from other resources, including benefits they may receive from the first program I referred to, the OASDI program. Over two-thirds of those people who are receiving benefits under the supplemental security income program are also receiving benefits under the OASDI program. That's of the aged. Over two-thirds of those who are aged and about one-third of those that are blind and disabled are also receiving benefits under the OASDI program.

Basically, this is a means tested program. We have uniform national eligibility standards. The recipient must be aged, blind, or disabled and the recipient must have limited income and resources, and we do have dollar limits on both income and resource amounts.

States do supplement in some cases the basic SSI benefit. As of now, 48 States plus the District of Columbia provide supplemental payments to individuals in these categories. There is also a provision which authorizes the Social Security Administration to administer those supplemental payments when requested to do so by the States. As of now some 26 States plus the District of Columbia have asked us to administer and we do, in fact, administer their supplemental payments.

AID TO FAMILIES WITH DEPENDENT CHILDREN

The next program is the aid to families with dependent children program. The basic idea of this program is to provide cash payments to needy families with dependent children. It's jointly financed by Federal, State, and in some States local funds through formula grants to States from Federal general revenues. It is administered at the State and local level within broad Federal statutes and regulations.

The program provides payments for children who are deprived of financial support of one parent due to death, incapacity, absence from the home, and in some States, unemployment.

The payment is related to a State-established standard of need and takes into consideration income and resources available to the recipient.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

Another program that we administer is the special benefits for disabled coal miners program. This program provides cash benefits to coal miners who are disabled due to what is known as black lung disease and to their dependents and survivors. Currently, this program is jointly administered by the Social Security Administration and the Department of Labor. The division of responsibility is as follows: Social Security serves those who applied for black lung benefits in 1973 or earlier.

Senator CHILES. How many of those are there?

Mr. DOGGETTE. There are about 400,000 of those beneficiaries right now, sir. That program is financed from general revenues.

Senator CHILES. What kind of dollars are we talking about?

Mr. DOGGETTE. We're talking about $1 billion, I believe, for about 400,000 beneficiaries. The Department of Labor, sir, serves those who apply for benefits in 1974 or later.

Now these benefits administered by the Department of Labor are financed by a tax on coal production. The Department of Labor adjudicates these claims and pays the benefits from a trust fund. However, SSA still takes the applications for the program administered by the Department of Labor.

Senator CHILES. About how many people are we talking about on that?

Mr. MONTELL. Sir, I don't have that number, Can I supply that for you for the record?

Senator CHILES. Please. What about dollars?

Mr. DOGGETTE. We'll supply both the number and the dollars for the record, sir. I apologize for not having that number handy.

We do take these applications, however, and we are reimbursed by the Department of Labor for taking those applications for those who applied after 1973.

Again, the program principles here are that the program is based on total disability or death due to black lung arising from coal mine employment and it is not a means tested program.

[The information follows:]

Under the Department of Labor black lung program, about 68,000 beneficiaries were receiving monthly benefits and medical services at the end of fiscal year 1980. An additional 88,500 were receiving medical services only. Total obligations amounted to $731,195,000. Total outlays were $721,746,000.

LOW-INCOME ENERGY ASSISTANCE PROGRAM

The low-income energy assistance program is also administered by the Social Security Administration. The basic idea of this program is to help low-income households meet rising home energy costs through payments to eligible households, their energy suppliers, or operators of public housing. It is financed from general revenues and the aid is provided through block grants to States and also through the energy crisis intervention program which is run by the Community Services Administration.

The program principles are as follows: The household must be responsible for its energy costs; the highest benefits go to the households with the lowest income and the highest energy cost relative to that income. The States do have flexibility in designing their programs to meet these needs.

PROGRAM ADMINISTRATION

This chart, Mr. Chairman, is merely designed to give you some visual idea of the SSA growth indices from the period of 1972 to the present. The solid line represents work output and we are using 1972 as a base-year with 100 as the base unit, and it merely shows the increase in the work output of SSA.

The broken line represents the total work-years used to generate this work output. In the total work-years we include our full-time permanent work-years as well as what we refer to as "all other" work-years. That means temporary employees, part-time employees, and overtime usage.

The slashed line covers just the full-time, permanent positions that we have used. So that the difference between the slashed line and the broken line would represent temporary, part-time, and overtime work-years. The difference between the broken line and the solid line would represent the effect of automation and the increase in productivity of the work force of the Social Security Administration.

The bottom of the chart lists some of the major tasks that are involved in producing this workload output.

DISTRIBUTION OF SSA EMPLOYMENT

This chart is designed to give you a visual picture of where the workers perform their activities in the Social Security Administration and the kinds of activities that are performed in those locations.

Our total positions are divided up into three categories. The first category includes those positions performing staff and support services, which are basically in our 10 regional offices and in our central office. They include operational planning, management services, and other staff functions. About 9 percent of our employees perform in that category.

The bulk of our employees, as you can see, work in field workload operations areas and this includes the employees who work in our district and branch offices and our teleservice centers, and we have approximately 1,367 of those offices, 127 hearing offices where our hearings are conducted, 10 field assessment offices where we review the program from a quality review standpoint, 6 program service centers where we have large operations which do a lot of our manual work, and 3 data operations centers which are decentralized systems input kinds of operations. About 75 percent of our employees work in these areas.

Then we have about 16 percent of our employees who work in workload operations areas which are performed at our headquarters locations in both Baltimore and Washington. These workload operations include our large disability operation, our central records operation, and our computer operations.

NONAPPROPRIATED VERSUS APPROPRIATED ACCOUNTS

As you indicated in your opening remarks, Mr. Chairman, not all of our funds are appropriated by the committee and we have merely listed on this chart the SSA request for annual appropriations from the Congress, indicating which accounts those are, and indicating which accounts are appropriated based on substantive legislation and do not require an annual appropriation from the committee.

This concludes the charts that I have. I'd like to ask Mr. Lou Hays now to cover the last chart which is on the program for which he is the acting director.

Senator CHILES. All right, sir.

Mr. HAYS. Thank you, Mr. Chairman.

CHILD SUPPORT ENFORCEMENT PROGRAM

The child support enforcement program is a Federal, State, and local effort to collect child support from absent parents. While the program is aimed primarily to benefit children receiving public assistance through the aid to families with dependent children program, the services of the program are also available to families who are not receiving public assistance, the category that we refer to generally as non-AFDC cases.

The concept of the program is to place the responsibility for supporting children on the parents of the children as opposed to you and me as taxpayers through the public welfare programs. The bulk of the actual work of locating absent parents, establishing paternity, and collecting support is performed at the State and local level. The Federal Government provides 75 percent of the State and local administrative costs and also provides a variety of services and assistance to State and local government.

PREPARED STATEMENT AND CHARTS

Mr. DOGGETTE. We will submit our statements regarding the individual accounts for the record, Mr. Chairman.

Senator CHILES. All right, sir.

[The statement and charts follow:]

Statement of Herbert R. Doggette, Jr.

Introduction

Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss SSA's appropriation accounts:

- Payments to Social Security Trust Funds
- Special Benefits for Disabled Coal Miners
- Supplemental Security Income
- Assistance Payments
- Limitation on Administrative Expenses

As you realize, we are operating under the Continuing Resolution through June 5th. For 1981 the Continuing Resolution provides authority for SSA to meet all its benefit payment obligations as they occur, and to spend for administrative expenses at the level approved by the House.

"Payments to Social Security Trust Funds"

The first appropriation funds three Federal fund payments to the Social Security Trust Funds. The payments are necessary to make the trust funds whole for the cost of certain benefits, or administrative expenses, borne by the trust funds initially, but ultimately chargeable to Federal funds. The three payments cover the following:

1. Reimbursement to the OASI and DI trust funds for the costs of benefits paid as a result of granting social security credits for certain earnings from military service on which servicemen were not required to pay social security taxes.

2. Reimbursement to the OASI trust fund for benefits paid to certain elderly persons age 72 or older who did not have a chance to work long enough under social security to become insured, but were allowed special benefits.

3. Reimbursement to the OASI trust fund for the administrative costs incurred by the Social Security Administration in maintaining records of the vested pension rights of individuals in private pension plans and in advising these individuals of their rights upon their request, or when they apply for social security benefits.

"Special Benefits for Disabled Coal Miners"

This appropriation funds the Social Security Administration's benefit and administrative costs related to the Black Lung program. The Black Lung program is authorized by title IV of the Federal Mine Safety and Health Act of 1977, which provides for payment of monthly cash benefits to coal miners who are totally disabled because of pneumoconiosis, commonly referred to as black lung disease, and to widows of miners who are entitled to these benefits or whose deaths were due to this disease. Payments to miners or widows are increased for dependents--a spouse or child. Benefits also are payable to surviving children of miners and in certain circumstances to totally dependent surviving parents, brothers, and sisters.

The Social Security Administration is responsible for processing and paying claims for miners' benefits filed from December 30, 1969 through June 30, 1973, and claims for survivor benefits filed through December 31, 1973, or within 6 months after the death of a miner or widow already on the beneficiary roll maintained by SSA. SSA must continue to pay benefits and to maintain the beneficiary roll for the lifetime of all persons who filed with SSA during its jurisdiction. The beneficiary roll--and the administrative cost of maintaining it--will continue to decline gradually in the years to come.

Since June 30, 1973, SSA has continued to take miners' claims, but as an agent of the Department of Labor, which is responsible for adjudication and payment of these claims and thus budgets to reimburse SSA for this work.

"Supplemental Security Income Program"

The Supplemental Security Income (SSI) appropriation provides funds through direct cash assistance to eligible aged, blind and disabled recipients to help finance their basic needs. The four activities are:

Federal Benefit Payments: The SSI program ensures a minimum monthly level of income to eligible aged, blind and disabled individuals. An individual's income, resources and living arrangement are evaluated to determine the actual amount of SSI payment. Payments are delivered through recurring monthly benefit checks.

Beneficiary Rehabilitation Services: Funds requested for this activity are to provide vocational rehabilitation services to disabled SSI recipients, and to monitor the treatment of certain disabled SSI recipients who are drug addicts or alcholoics.

Federal Fiscal Liability: The Social Security Administration administers supplemental payment programs for 26 States and the District of Columbia. The requested funds are for reimbursement to the States for State supplemental funds incorrectly paid by the Federal Government--in excess of contractural error tolerances--as a result of Federal errors only.

Payments to Trust Funds for Administrative Costs: The SSI and Social Security programs are administered on an integrated basis for purposes of economy and efficiency. The Social Security Act authorizes advances from the Social Security Trust Funds to pay the administrative costs of the SSI program through the Limitation on Administrative Expenses. The advances are fully repaid from the SSI appropriation through this activity. SSA maintains a detailed cost allocation system which has been audited by the General Accounting Office to ensure that the trust funds are made whole (with interest, if appropriate) for the administrative expenses of the SSI program.

"Assistance Payments"

The assistance payments appropriation provides funds through grants to the States and local governments to help finance support for the needy. Although the Social Security Administration is responsible for the programs covered by this appropriation, no trust fund money is used for assistance payments purposes.

Maintenance Assistance

This activity provides funding for the Federal share of the following maintenance assistance programs:

--Aid to Families with Dependent Children
--Assistance to aged, blind and disabled adults in Guam, Puerto Rico and the Virgin Islands; the supplemental security income program does not cover these jurisdictions.
--Emergency assistance to needy families with children under 21.
--Assistance to repatriated U.S. Nationals returning from foreign countries who have been certified by the Department of State as distitute or ill, and
--State and local administration and training related to these maintenance assistance programs.

Child Support Enforcement

This activity provides funding for the net Federal share of the child support enforcement program. The aim of the Child Support Enforcement program is to reduce welfare costs by assuring that absent parents meet their responsibility to support their children. CSE services are available to AFDC families as well as to non-AFDC families who request them. The Office of Child Support Enforcement provides technical assistance and guidance to the States through the issuance of regulations, program manuals and on-site reviews of procedures for making child support collections. Under the Child Support Enforcement program, support payments made by absent parents on behalf of AFDC recipients go to State or local child support enforcement agencies for distribution. Collections are used to reimburse State and Federal costs of paying AFDC.

Research and Evaluation

Sections 1110 and 1115 of the Social Security Act authorizes research and evaluation grants and contracts to develop and finance experimental projects to explore new ways to prevent and reduce dependency on public assistance, improve coordination of planning between private and public welfare agencies, and improve the administration and effectiveness of programs carried out under the Social Security Act. Most of the money is for research and demonstration projects related to the AFDC and Child Support Enforcement programs, but some of the funds are used for social security and SSI extramural research grants and contracts.

Federal Administrative Expenses

The Assistance Payments appropriation request includes funding to cover Federal administrative expenses related to maintenance assistance, child support enforcement, and research and evaluation activities.

"Limitation on Administrative Expenses"

The Limitation on Administrative Expenses is a request for authority to spend from the trust funds for the administrative expenses of the Social Security Administration. This account provides funds for the administration of the retirement, survivors, and disability insurance programs, Medicare work performed by SSA, and the construction needs of the social security trust fund programs. In addition, because SSA administers both trust fund and non-trust fund programs on an integrated basis, for purposes of economy and efficiency, the law authorized that certain other administrative costs be funded from this account, with later full reimbursement from general funds. The non-trust fund work handled in this way includes work relating to the Supplemental Security Income program, work associated with the Pension Reform Act of 1974, and that portion of annual wage reporting work done by SSA for the benefit of the Internal Revenue Service.

SSA has a workload-based administrative budget, whose size is determined primarily by workloads generated by provisions of the law and demographic factors. In developing its administrative budget, SSA first arrives at the work-years necessary to process the estimated work that will come to the agency. SSA also keeps careful track of its own productivity and includes estimates of productivity in its annual budget request. Productivity is a measure of the relative change from year to year in the ratio of total work accomplished to workpower used. To keep track of workloads and productivity, SSA uses a work measurement system in each operating component to collect data on various work outputs and the work-years of employee effort associated with each type of output.

Regulations Statement

Neither the Social Security Administration nor the Office of Child Support Enforcement is a regulatory agency. SSA/OCSE regulations closely parallel authorizing statutes and do not impose a compliance cost on the private sector or, with limited exceptions, on the States. No regulations have had cost impact of a significance great enough to require regulatory analysis under Executive Order 12044, which is intended to identify Federal regulations with large compliance costs.

In a broad sense, all the agency's employees are engaged in carrying out the law and regulations. Approximately 80 positions and work-years are devoted to the specific task of developing and promulgating regulations for the programs which SSA and OCSE administer.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

Name: HERBERT R. DOGGETTE, JR.

Position: Acting Commissioner, Social Security Administration, Department of Health and Human Services, since January 1981.

Former Positions: Acting Deputy Commissioner for Operations, Social Security Administration, July 1979 - January 1981.

Acting Associate Commissioner for Management, Budget, and Personnel, Social Security Administration, January 1979 - July 1979.

Acting Deputy Assistant Secretary for Equal Opportunity Programs, Department of Health, Education and Welfare, April 1978 - December 1978.

Deputy Director, Bureau of Retirement and Survivors Insurance, Social Security Administration, August 1975 - April 1978.

Assistant Bureau Director, Administration, Bureau of Retirement and Survivors Insurance, Social Security Administration, June 1973 - August 1975.

Director, Labor Relations and Equal Opportunity Staff, Bureau of Retirement and Survivors Insurance, Social Security Administration, September 1969 - June 1973.

Congressional Fellowship Program, November 1968 - August 1969.

Other operational and management positions with Social Security Administration, September 1958 - November 1968.

Military Service, U.S. Army, July 1954 - July 1956.

Education: University of Maryland, BA - Business Administration, 1975.

George Washington University, MPA, June 1978.

Awards: Social Security Administration Commissioner's Citation, 1966 and 1973.

Secretary's Special Citation, 1979.

National Civil Service League Awards, 1980.

Awarded Rank of "Distinguished Executive" in the Senior Executive Service, 1980.

Personal Data: Born in Brooklyn, New York, on December 7, 1933. Married with three children.

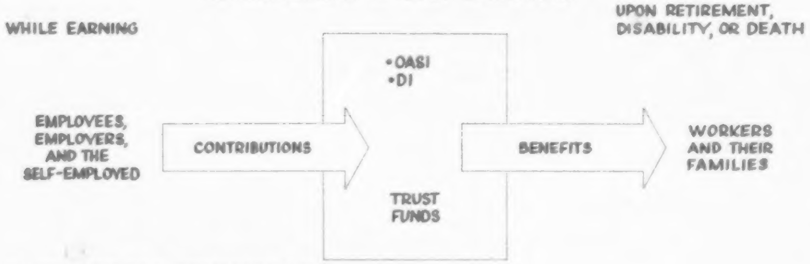
SOCIAL SECURITY ADMINISTRATION
OFFICE OF CHILD SUPPORT ENFORCEMENT
PROGRAM OVERVIEW

- Old Age and Survivors Insurance
- Disability Insurance
- Supplemental Security Income
- Aid to Families with Dependent Children
- Special Benefits for Disabled Coal Miners
- Low Income Energy Assistance
- Child Support Enforcement Program

SOCIAL SECURITY (OASDI) BENEFITS

- **BASIC IDEA OF THE CASH BENEFITS PROGRAM**

REPLACEMENT OF LOST EARNINGS


WHILE EARNING
UPON RETIREMENT, DISABILITY, OR DEATH
•OASI
•DI
EMPLOYEES, EMPLOYERS, AND THE SELF-EMPLOYED
CONTRIBUTIONS
BENEFITS
WORKERS AND THEIR FAMILIES
TRUST FUNDS

- **PROGRAM PRINCIPLES**
  - --Work related
  - --Earned Right--No Means Test
  - --Contributory (with limited exceptions)
  - --Compulsory

SUPPLEMENTAL SECURITY INCOME

- BASIC IDEA OF THE PROGRAM
  - --Provides cash payments from general revenues to assure a minimum national income level for the aged, blind and disabled.
  - --Supplements income from other sources, including OASDI benefits.
    - Over 2/3 of aged SSI recipients also receive OASDI benefits.
    - One-third of blind and disabled SSI recipients also receive OASDI benefits.

- PROGRAM PRINCIPLES
  - --Means tested
  - --Uniform national eligibility standards.
    - Recipient must be aged, blind or disabled.
    - Recipient must have limited income and resources.
  - --States supplement SSI benefits.
    - 48 States + D.C. provide supplement.
    - Of these, 26 States + D.C. choose to have SSA administer the supplement.

AID TO FAMILIES WITH DEPENDENT CHILDREN

- BASIC IDEA OF THE AFDC PROGRAM
  - --Provides cash payments to needy families with dependent children.
  - --Jointly financed by Federal, State and (in some States) local funds through formula grants to States from Federal general revenues.
  - --State and local administration within broad Federal statute and regulations.

- PROGRAM PRINCIPLES
  - --Payments are for children deprived of the financial support of one parent, due to death, incapacity, absence from the home, or (in some States) unemployment.
  - --Payment is related to State established standard of need--takes into consideration income and resources available to the recipient.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

- BASIC IDEA OF THE PROGRAM
  - --Provides cash benefits to coal miners disabled due to Black Lung disease and to their dependents and survivors.
  - --SSA Program
    - Serves those who applied in 1973, or earlier.
    - Financed from general revenues.
  - --Department of Labor Program
    - Serves those who applied in 1974 or later.
    - Financed by Coal Mine Operators and Black Lung Trust Fund (Tax on coal production)
    - DOL adjudicates and pays benefits.
    - SSA takes applications; is reimbursed by DOL.

- PROGRAM PRINCIPLES
  - --Based on total disability or death due to Black Lung arising from coal mine employment.
  - --Not means tested

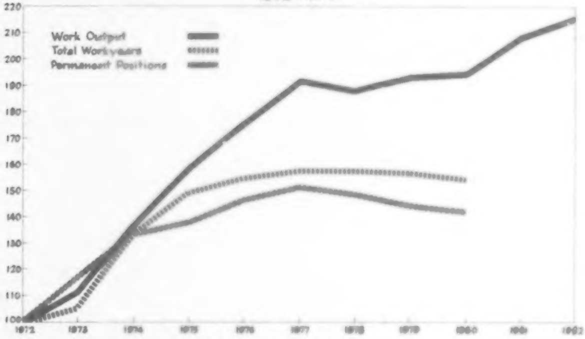
LOW INCOME ENERGY ASSISTANCE PROGRAM [1]

- BASIC IDEA OF THE PROGRAM
  - --Help low income households meet rising home energy costs through payments to eligible households, their energy suppliers, or operators of public housing.
  - --Financed from general revenues.
  - --Federal aid provided through block grants to States and through Energy Crisis Intervention Program run by Community Services Administration.

- PROGRAM PRINCIPLES
  - --Household must be responsible for its energy costs
  - --Highest benefits go to households with lowest income and highest energy cost relative to income.
  - --Flexibility for States in designing plans to meet their needs.

[1] Program described is 1981 program--program for 1982 not yet authorized.

PROGRAM ADMINISTRATION



SSA Growth Indices:

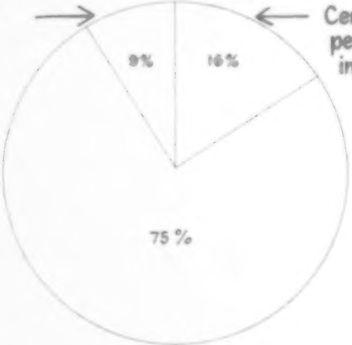
1972 = 100

SSA Tasks Include:

- Processing claims.
- Processing reconsiderations, hearings and appeals.
- Keeping the benefit rolls up to date.
- Checking on the continuing eligibility of beneficiaries.
- Issuing, verifying and correcting social security numbers.

DISTRIBUTION OF SSA EMPLOYMENT

(TOTAL POSITIONS)



Staff and support services →
e.g. Regional Offices
Central Program Direction
Operational Planning
Management Services

← Central workload operations performed at Baltimore/Washington headquarters
e.g. Disability Operations
Central Records Operations
Computer Operations

↑
Field workload operations performed nationwide
e.g. 1367 District and Branch Offices, and Teleservice Centers
127 Hearing Offices
10 Field Assessment Offices
6 Program Service Centers
3 Data Operations Centers

NON-APPROPRIATED VS. APPROPRIATED ACCOUNTS

- FUNDS FOR THE FOLLOWING ARE PERMANENTLY APPROPRIATED BY SUBSTANTIVE LEGISLATION:

	Outlays ($ in Millions)	
	FY 1981	FY 1982
Old Age and Survivors Insurance Benefits	$119,548	
Disability Insurance Benefits	16,862	
Vocational Rehabilitation (OASDI Program)	86	
Disability Research	1	

- SSA REQUESTS ANNUAL APPROPRIATIONS FROM CONGRESS FOR THE FOLLOWING:

	Appropriation ($ in Thousands)	
	FY1981[1]	FY1982
Payments to Social Security Trust Funds	$672,066	
Special Benefits for Disabled Coal Miners (Black Lung)	1,126,479	
Supplemental Security Income	7,392,527	
Assistance Payments	8,304,502	
Limitation on Administrative Expenses	2,794,564	
Survey of Income and Program Participation	--	
Low Income Energy Assistance Program	1,850,000	
Total Appropriation Request	$22,140,138	

[1] Reflects annualization of the Continuing Resolution, which runs out on June 5.

CHILD SUPPORT ENFORCEMENT PROGRAM

- BASIC IDEA OF THE PROGRAM
  - -- Aim is to reduce welfare costs by assuring that absent parents meet responsibility for supporting their children.
  - -- State must have Child Support Enforcement Program in order to receive federal funding for AFDC
  - -- Child support payments for AFDC recipients are paid to the state -- collections are used to reimburse state and federal costs of paying AFDC.
  - -- Child support services also provided for non-AFDC families -- to prevent their dependency on welfare.

- PROGRAM PRINCIPLES
  - -- AFDC recipients required to assign child support rights to State and to cooperate in establishing paternity and securing support.
  - -- Federal/State partnership: Federal government shares costs of state and local administration and operations.

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

	($ In Thousands)	
ACTIVITY	FY 1981	FY 1982
Military Service Credits	$520,516	
Special Payments for Certain Uninsured Persons	149,809	
Pension Reform	1,741	
Survey of Income and Program Participation	—	
Total Appropriation	$672,066	

- Makes the OASDI Trust Funds whole by reimbursing them for the cost of benefit payments and administrative expenses chargeable to Federal funds.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

(BLACK LUNG)

ACTIVITY	($ In Thousands) FY 1981	FY 1982
Benefit Payments	$1,121,299 [1]	
Administration	5,180	
Total Appropriation	$ 1,126,479	

- Pays for cash benefits to coal miners who are totally disabled due to coal miners pneumoconiosis (Black Lung) and to their widows and certain other dependents, and for related administrative expenses.

[1] Includes $34,299 thousand appropriated in 1981 to fund 1980 shortfall.

SUPPLEMENTAL SECURITY INCOME

ACTIVITY	($ In Thousands) FY 1981	FY 1982
Federal Benefit Payments	$6,489,465 [1]	
Hold-Harmless Payments	45,000	
Beneficiary Services	38,351	
Payments to the Trust Funds for Administrative Costs	772,100	
Federal Fiscal Liability	47,611	
Total Appropriation	$7,392,527	

- Pays for cash benefits and rehabilition services for needy, aged, blind and disabled people, and for related administrative expenses.
- Reimburses States for errors made by the Federal government in disbursing State Supplementation funds.

[1] Includes $137,465 thousand appropriated in 1981 to fund 1980 short fall.

ASSISTANCE PAYMENTS

ACTIVITY	($ In Thousands) FY 1981	FY 1982
Maintenance Assistance		
AFDC	$7,243,037 [1]	
Adult Categories (Guam, Virgin Islands, Puerto Rico)	13,346	
Emergency Assistance	54,600	
State and Local Administration and Training	784,900	
Repatriation	1,519	
Subtotal	8,097,402	
Child Support Enforcement		
Collections (Offset to AFDC)	-261,000	
State and Local Administration and Training	419,000	
Research and Evaluation	3,500	
Federal Administrative Expenses	45,600	
Total Appropriation	$8,304,502	

- Finances Federal share of costs in the AFDC, Child Support Enforcement and other assistance programs.
- Pays for the related Federal administrative costs of these programs, and for research and demonstration projects.

[1] Includes $478,337 thousand appropriated in 1981 to fund 1980 shortfall.

LIMITATION ON ADMINISTRATIVE EXPENSES

	($ In Thousands)	
ACTIVITY	FY 1981	FY 1982
Old Age and Survivors Insurance Program	$972,338	
Disability Insurance Program	855,715	
Health Insurance Program	117,148	
Supplemental Security Income Program	772,100	
Annual Reporting	62,022	
Pension Reform	1,741	
Construction	13,500	
Contingency Reserve	(50,000)	
Total Appropriation	$2,794,564[1]	

- Provides resources for SSA to administer the OASDI programs, certain health insurance functions, and SSI program.

[1] *Includes $199,700 thousand for pay raise supplemental*

ILLEGAL SOCIAL SECURITY CARDS

Senator CHILES. There's a considerable debate about the fraudulent use of social security cards by illegal immigrants to obtain various Government benefits. Some believe the Government should issue a tamper-resistant social security card which would effectively serve as a kind of a national identity card.

How does the immigrant obtain an illegal social security card?

Mr. DOGGETTE. Mr. Chairman, there are several ways that a person can obtain a social security card. Our basic requirement is that a person seeking a social security card must visit or come into a social security office and submit evidence of age, identity, and citizenship or alien status in order to be issued a card.

We have tightened up our procedure considerably since we have become aware of the problem. A person could obtain one by having fraudulent documents. We are taking steps with that by working with the Immigration and Naturalization Service to develop a training program for our district office people who issue these cards to be sure they are better able to recognize INS documents to try to determine their authenticity.

We are also looking at developing a pilot program which would proide for some direct input and direct central issuance of social security cards so we can try to cut down on the potential that a person will be successful in obtaining an illegal card.

Senator CHILES. Can you tell me how much it would cost to issue a tamper-resistant social security card? An example would be one with a person's picture on it.

Mr. DOGGETTE. We looked at that a little while ago, Mr. Chairman. We determined that under the most cost-effective approach—issuing banknote paper-type cards—if we issued new or replacement cards to everyone currently having a social security card it would cost about $1.2 million annually to issue to those who were getting cards each year; and to reissue the cards to all those who have them—and there are some—I believe the figure is about 200 million people who have active social security cards now—it would cost us about $850 million. Cards with photographs would be considerably more costly and would involve serious logistical complications for the issuance process.

Senator CHILES. What actual plans does this administration have to stop the abuse of social security cards and the consequent abuse to the system by use of those cards?

Mr. DOGGETTE. Mr. Chairman, I mentioned a couple of the items that we have already undertaken to try to deal with that problem. I will try to mention a few more here.

We have developed security plans for the issuance of social security cards. Many social security cards are issued through the system's process now centrally. Some cards are issued in those 1,300-plus district offices that I mentioned on the chart. So they do have original stocked cards in district offices.

We have developed security plans for controlling the use and the access to those cards. We maintain inventory control ledgers and we insure that those cards are properly secured both during business and nonbusiness hours. We have installed a new inventory control system on our computers to monitor the use of these blank cards and to limit reorders to be sure that we keep much better track of where those cards are, who has them, and when they are issued.

We are developing a nationwide training program which has several phases to it. I mentioned the one of working with the Immigration and Naturalization Service to help us to determine when documents submitted—INS documents submitted—have a probability of being fraudulent. We have devised and issued a new application form in order to receive a social security card. We call that our SS–5 application which now has more information on it. And we have recently completed training all of our field employees who issue those cards on how to complete that application and how to get the necessary information.

We do require interviews with those who are over 18 who are receiving social security cards for the first time to make certain that they in fact have not had a card before and they do meet our requirements. And we will be doing special studies of all of our activities in this area to be sure that they are effective and if we find other gaps we will move very quickly to try to fill them, sir.

Senator CHILES. Do you have any estimate, sir, of how many illegal cards are out there now?

Mr. DOGGETTE. No, sir, I do not; no, sir, we do not have any estimate at this point.

Senator CHILES. Do we have any way of sort of checking now as to how many we're giving out? Is there any check that's actually done at all?

Mr. DOGGETTE. Mr. Chairman, in response to that, we know how many new cards that we are issuing each year and the study that I mentioned that we will be doing to look at how well——

Senator CHILES. What are the penalties for giving any kind of false information or for getting or holding or possessing an illegal card?

Mr. DOGGETTE. There is a penalty, sir. I don't have it handy. I will supply it for the record, with your permission. It is not a large penalty as we recall.

[The information follows:]

The Social Security Act currently identifies two social security number-related violations as misdemeanors subject to a fine of not more than $1,000, up to 1 year in prison, or both. One violation is the willful, knowing, and intentionally deceitful provision of false information as to identity in order to obtain a social security number. The other is use of a falsely obtained social security number or the representation as his own of a social security number not assigned to an individual in order to obtain or increase benefits to which the individual is not entitled, or for any other purpose. These violations are directed at the individual social security applicant or user. They do not address individuals or organizations that traffic in social security numbers.

PENALTY STATEMENT

Senator CHILES. It's not a large penalty. Is anybody told at the time they come to get a card that if they give some illegal information here there's a penalty connected with it or is the person required to certify when they get the card or make any kind of sworn statement that the information they are giving is correct?

Mr. DOGGETTE. On the application which an individual must fill out in order to receive a card, there is a penalty statement, sir.

Senator CHILES. I'd like to know what the penalty is. I don't think anybody knows, so it must not be very severe.

AID TO FAMILIES WITH DEPENDENT CHILDREN

While we're on the issue of illegal immigrants, let me ask you a related question regarding the AFDC. I understand that Los Angeles County runs a program to prevent illegal immigrants from obtaining welfare benefits and estimates that it saves $50 million a year in doing so.

What safeguards are there through the Federal administrative procedures that prevent an illegal immigrant from obtaining AFDC payments?

Mr. DOGGETTE. Mr. Chairman, I'd like to refer that question to Mr. Goldstein.

Senator CHILES. All right.

Mr. GOLDSTEIN. Mr. Chairman, as you know, the AFDC program is administered at the State level. I'm not familiar with the specific Los Angeles study you're referring to. By and large, we find that where there is a dollar value associated with illegal aliens, the largest amount of that turns out to be medicaid costs because of the fact that illegal aliens when they need public assistance usually turn up in the public assistance system in response to a medical need. However, there are steps that we take to prevent illegal aliens and others who aren't eligible for assistance from receiving it. We have a quality control system which monitors the extent to which those who are ineligible receive assistance and we require that States establish what we call corrective action plans to respond to that problem.

We also require that States take action against those in the illegal aliens group who are found to have received assistance.

Senator CHILES. It would seem like if we had a quality control plan and if it was a good one we would be looking at what a State would be doing in their quality control. If they can save $50 million, maybe that ought to be our quality control plan, should it not, or at least we ought to know about it?

Mr. GOLDSTEIN. If the State of California is making payments to that large an extent, then it will turn up in the quality control system and it will be part of the corrective action plan. I don't have the California corrective action plan here before me, so I can't say what that particular element is.

DISABILITY INSURANCE ERROR RATES

Senator CHILES. There's some evidence that error rates for the disability insurance program may be alarmingly high, as high as 15 or 20 percent, with losses up to $2 billion a year. What are the roots of this problem and what can be done to reduce this error rate?

Mr. DOGGETTE. Mr. Chairman, we conducted a study recently for the month of April 1979. It was a sample of the cases on the disability rolls during the month of April 1979. That pilot study did indicate that there may be substantial error rates in the disability program. There are a few caveats that need to be mentioned regarding that study, and that is that this was just for 1 month. It was sort of a camera shot and it may or may not be representative of the entire rolls because of that. We also need to evaluate the correctness of the decision and also take into account that some of those cases, if they went through an administrative appeal and judicial review process, might or might not end up on the rolls. They might wind up being put back on the rolls if they were removed.

But that pilot did indicate potential for erroneous payments in the $2 billion-plus category. By the way, I should add that we are going to expand this study. That first study was about 3,000 cases. We are now looking at some 25,000 cases to further validate the findings from that first study and to get a much firmer fix on just where those errors may be. We found some of those errors to involve instances where there may have been medical improvement in the person's condition from the time the person went on the rolls until the study was done. In other cases we found that the initial determination of disability itself may have been erroneous. In some cases we had cases that were transferred to the social security rolls when the SSI program was administered by the Social Security Administration and we're looking at some of those cases now to insure that only those persons who are supposed to be receiving disability benefits in fact do receive them.

1980 DISABILITY AMENDMENTS/EFFECT OF HIRING FREEZE

Senator CHILES. The disability insurance amendments of 1980 mandated a number of changes in the administration of the disability insurance program. Many of those required additional work to verify beneficiaries' eligibility for disability insurance.

What steps has the Department taken to implement those initiatives and will the current hiring freeze have any impact on your ability to make those needed changes?

Mr. DOGGETTE. Mr. Chairman, we have put together a work group within the Social Security Administration to insure that we implement all of the provisions of the 1980 disability amendments and I'm pleased to report that we are on schedule in implementing those provisions of the act.

As to the impact of the freeze, basically, when the Carter freeze was implemented we were in a relatively good condition as an agency. We were pretty well staffed up and we had another occurrence during the year that turned out to be beneficial in that regard and that is that the workloads that we had anticipated in some key areas did not materialize. So we did have some capacity in the administration to take on this additional responsibility and for the most part we have been able to do it within the resources that we have had during this period.

The current freeze may have some impact down the road. To this point it has not seriously affected our ability to carry out our essential work.

DISABILITY STATE AGENCIES

Senator CHILES. How many States are handling disability insurance? I understand they have the option to handle that, to use State employees and then the Federal Government reimburses 100 percent I think the cost of that. How many States are doing it that way and how many are actually having the Federal Government administer the program in the States?

Mr. DOGGETTE. Sir, all States are working with the Federal Government in a Federal-State relationship to make the disability determinations. The process basically is we take the application in the social security district office and develop the case to a certain extent and we send it then to the State where the disability determination is made by the State. It is then sent back to the Social Security Administration for final processing, either payment or disallowance.

Senator CHILES. But am I not correct that you can have a State operation of the social security disability determination program or you can have a Federal operation of that, depending on whether the States have opted to do it themselves or have the Federal Government do that?

Mr. DOGGETTE. Yes, sir; you're correct in that.

Senator CHILES. How many States have opted to do that? Are you saying all of them have?

Mr. DOGGETTE. None have opted to implement it on their own as of this point. All States are in a relationship now with the Federal Government to make the disability determination.

Senator CHILES. My understanding is that they can opt to get out of that relationship.

Mr. DOGGETTE. Yes, they can.

Senator CHILES. How many have opted to get out and say let the——

Mr. DOGGETTE. We have no formal notice at this point from any State.

Senator CHILES. I understand you're about to get one from the State of Florida and what I'm trying to understand is why would States be talking about giving it back to the Federal Government?

Mr. DOGGETTE. We have heard, Mr. Chairman, that the State of Florida has in fact submitted a budget to the legislature which does not provide for funding the disability program after the end of this fiscal year. The 1980 disability amendments require that we be given a 6-month notification before a State may withdraw. So if in fact the State of Florida wanted to proceed with that, we would have to receive formal notification by May 1. We have not yet received such notification.

Our regional commissioner has met with Secretary Taylor and other members of the State to discuss the very issue that you raised, just what the prospects may be. At this point we are not really sure why the State of Florida is proposing to give notice, if in fact they do follow through with that.

We have talked about their ability to carry out the function and it is our desire—our strong desire—to work with them in such a way that it will convince them that they should stay in the relationship with us.

Senator CHILES. What will the effect be if Florida opts to come out of the program?

Mr. DOGGETTE. Then the Federal Government would have to take over the administration of that part of the program.

Senator CHILES. These people that are now classified as State employees would be classified as Federal employees or would-be Federal employees?

Mr. DOGGETTE. It would depend, sir, on what methodology was used to take over that responsibility. There are several options open to the Federal Government on how to take it over. We were required under the 1980 amendments to submit a plan to the Congress—a contingency plan on some of the options that would be available to us in the event States opted to get out of the program—and we did submit that plan.

Some of the options would be to have it done in a neighboring State. Another option would be to take it over as a Federal operation.

Senator CHILES. You mean we would have Georgia employees, Alabama employees handling the disability insurance—would we have to go to Atlanta or Birmingham to do that?

Mr. DOGGETTE. I would not commit SSA to pursuing that option aggressively, but it is an option available to the Federal Government in looking at that, sir.

Senator CHILES. I notice that the new administration is saying—for example, I saw that they were talking about discontinuing legal services totally, and the plan would be just to give that back to the States and allow the States to handle legal services.

Do you think that the States are sort of looking at their hand and seeing what they can give back to the Federal Government and we're going to be having this kind of game—"I give you this and you can have this"—"You get Boardwalk and I'll have Park Place."

Mr. DOGGETTE. That may be a possibility.

Senator CHILES. For example, the State of Florida, my understanding is, could say that they cut their State employees by *x* number of employees if they turned this back to the Federal Government.

Mr. DOGGETTE. That is correct. In fact, there are some—I believe the number is about 402—employees working in the State disability determination unit in five different cities in the State of Florida now.

Senator CHILES. What would this do to your hiring freeze, if you had 402 employees that suddenly were on your doorstep?

Mr. DOGGETTE. Well, I'm sure we would get the necessary resources to take over that responsibility if in fact we had to assume it, but as I indicated, our major effort is going to be to continue to work with the State of Florida to see if we can convince them that it's a better relationship for them to stay in the program and to make those determinations for the people in the State of Florida.

QUALITY ASSURANCE

Senator CHILES. A major concern of this committee has been the reduction of waste, fraud, and abuse in the Government's income maintenance programs. You mentioned in your opening statement that you calculate productivity measures for your work force. Do those measures include a measure of the accuracy of the determinations of eligibility and benefit levels or are they just including a number of cases processed?

Mr. MONTELL. They do include a factor for the quality of the end product as well as for the quantity.

Senator CHILES. In your account, limitation on administrative expenses, how much money and how much time was devoted to these quality assurance matters?

Mr. MONTELL. We have in the Social Security Administration central responsibility for this kind of quality assurance work in the Office of Assessment, and in fiscal year 1980 about 2,500 work-years and about $72 million was devoted to this activity. This doesn't include work that's done throughout all the operations of SSA in both the district offices and the program service centers and, for that matter, in the State agencies. That's so woven into the fabric of everything we do that it would be hard to identify a separate number for that, but we do have one office functioning solely for quality assurance.

CHILD SUPPORT ENFORCEMENT

Senator CHILES. Going to child support now, the child support enforcement program, as you mentioned, is designed to assure that absent parents meet their responsibilities to support their children. I note that in fiscal year 1981 the Federal estimates for collections, administrative costs, and child support programs have changed significantly. The estimates for collections under this program have dropped from $325 to $261 million. That's a drop of $91 million. While the cost of the administration has jumped from $310 to $419 million, an increase of $109 million. That would be the first time in several years that costs exceeded collections, would it not, and what's the reason for that?

Mr. HAYS. Well, first, Mr. Chairman, costs in the aggregate will not exceed collections. In fact, we will continue to collect in excess of $3 nationwide for every $1 of expenditure. It is true that costs are increasing. We face the dilemma that——

Senator CHILES. You continue to collect $3 for every $1 you spend now?

Mr. HAYS. For example, in fiscal year 1980, just concluded, the national figure was approximately $3.30 of collections for every $1 of expenditure.

The problem that the Federal Government faces, Mr. Chairman, in the child support program is that for every $1 that is spent at the State and local level, we pay out 75 cents of that $1. For every $1 of child support that is collected, we get in essence nothing for the non-AFDC collection, and from every $1 of child support from the AFDC case we get on the average a 37-cent return.

So because of the way the statute itself is set up, it's extremely difficult for the Federal Government to, in effect, show a net profit. Again, using fiscal year 1980 as an example, the States in the aggregate enjoy the net savings of over $230 million, whereas the Federal Government had a net loss, if you will, of approximately $91 million. Of course, that doesn't take into account what we think are substantial indirect benefits of the program. We think, for example, that when we collect money from people who are not receiving public assistance that we are helping to keep a number of families off of AFDC.

Senator CHILES. All right. Tell me why the estimate of collections is dropping so sharply.

Mr. HAYS. Unfortunately, some of the earlier year projections of what we had hoped to collect in the future turned out to be overly optimistic. However, we are very optimistic about the effects of the President's economic recovery program on the child support program.

Senator CHILES. You mean that what you had earlier was just estimates. You never collected that much?

Mr. HAYS. No, I'm sorry; I didn't mean to suggest that. Earlier estimates of what we would be collecting in the future were somewhat overly optimistic. In fact, our collection——

Senator CHILES. Is there a drop in the actual collections—let's forget about the estimates.

Mr. HAYS. There is no drop.

Senator CHILES. Is there an increase in the collection?

Mr. HAYS. Yes; there is an increase in collections.

Senator CHILES. You didn't estimate very well, but your collections have continued to go?

Mr. HAYS. Yes; for example, in Florida, the collections increased by some 25 percent in fiscal year 1980 over the previous fiscal year.

Senator CHILES. All right. My understanding is that the administration is proposing to shift some of those costs and either charge a fee to the people that they are presently collecting for that are not AFDC recipients or to charge the States a higher fee. Is that correct?

Mr. HAYS. There are four items in the President's economic recovery program, Mr. Chairman, that will affect the child support program. The aggregate effect of those proposals will be to significantly increase child support collections and also to reduce both the State and the Federal share of administrative costs. There would be some readjustment of the current structure of the program to address the problem which I mentioned earlier, namely, that the Federal Government puts up 75 cents of every $1 of expenditure but gets back only 37 cents of every $1 of collections from AFDC families.

Senator CHILES. But you mentioned the rationale of the program is that we're trying to have the parent pay for the child rather than the Government. It seems like when Senator Long was really designing this program, and when it went before the Congress, we recognized the fact that we were going to make some collections for people that were not on AFDC, but I think we felt that was justified because but for those collections—but for the fact that the parent would be required to pay for the child, they could be on AFDC. So if we turned around and said, "Because you're not on AFDC, we're going to charge you a fee," what's to keep that mother from saying, "If I've got to pay a fee, I might as well just forget the collections and sign up for AFDC," and let the Federal Government have the burden to help her?

Mr. HAYS. I would point out that, first of all, the fee would not in effect be a direct charge to the mother. It would in fact be a deduction from the amount that she would otherwise receive, and the amount——

Senator CHILES. You don't think that the mama is going to know that?

Mr. HAYS. Of course she will, but she's not going to have to spend her own money up front, so to speak. In fact, the current law does allow the States to charge up front an application fee to these——

Senator CHILES. Do you make a deduction from her AFDC check?

Mr. HAYS. No, the AFDC mother does receive a full AFDC payment.

Senator CHILES. That's right, no deduction for the collection of that?

Mr. HAYS. That is correct.

Senator CHILES. But you collect from her if she wasn't on AFDC. I don't see the logic and rationale in that and that isn't going to save you any money if you go that way.

SYSTEMS SECURITY

What have you done about computer security?

Mr. DOGGETTE. Mr. Chairman, we have a new national computer center recently completed which we plan to move into during 1981. In the current location where we house our computer operations, we have upgraded our security substantially and we have put in all sorts of security devices. We have limited access to security areas and tried to improve the security of the current location. The new building has all of the latest security features built into it and once we get into that building, not only internal security but permanent security will be greatly improved.

PROPOSED ELIMINATION OF STUDENTS BENEFITS

Senator CHILES. Going now to the proposed elimination of social security student benefits, it's one of the major cost-savings proposals of the Reagan administration, the rationale for the reduction of these is that these students are eligible for higher education loan and grant assistance provided by the Department of Education.

How many students now receive the social security benefit?

Mr. DOGGETTE. Mr. Chairman, I think that number—and I'll find it in just a second—is about 700,000.

Senator CHILES. Of these, how many presently receive aid from one of the Department of Education's loan programs?

Mr. DOGGETTE. Mr. Chairman, I do not have the number for that.

Senator CHILES. Well, has the administration's calculations of savings as a result of the elimination of this program taken into account the possibility that the cost of student loan and grant programs are going to increase as a result of the cutback so that we can see what is the benefit ratio by that offsetting increase it will go up?

Mr. THOMPSON. Mr. Chairman, it's my understanding that the Department of Education is making those calculations since the impact is in their budget.

Senator CHILES. Well, the Reagan proposal would not only stop new people from getting their benefits, but it would cut payments to the current recipients by 25 percent a year, the ones that are now receiving it. Given the timing of the Federal grant programs, how much of that loss could be picked up by other grants in the coming school year? Do you have any information on that?

Mr. THOMPSON. No, I don't have. My understanding would be that if the Congress enacted the changes in the timeframe suggested by the administration—that there would be sufficient time for students whose social security benefits had been reduced to make application for some alternative forms of assistance.

SUBMITTED QUESTIONS

Senator CHILES. We will have some other questions we will ask for the record.

Now let's turn to the subject of assistance to State and local governments for the cost incurred by the large inflows of refugees. We are going to change panels now. Thank you all very much.

Mr. DOGGETTE. Thank you, Mr. Chairman.

[The following questions were not asked at the hearing but were submitted for response for the record:]

Questions Submitted by the Subcommittee

SUPPLEMENTAL SECURITY INCOME/DEFINITION OF RESOURCES

Senator Stevens: The Supplemental Security Income Program was intended to provide funds for low income people but some of the policies work against the Native culture in Alaska. Native Alaskans hold fishing permits which are considered resources for SSI purposes and are used to reduce or eliminate monthly benefits. I am considering introducing legislation which will recognize the rights of native people and will allow the SSI program to meet its intended purpose of providing income to the needy. Can you tell me why the Social Security Administration has not adopted realistic policies which accomodate the needs of Native Alaskans?

Answer: Section 1611(a) of the Social Security Act requires that we take into consideration an individual's resources, with specific exclusions listed in section 1613, in determining eligibility under the supplemental security income (SSI) program. Regulations (20 CFR 416.1201) for the SSI program define resources generally as any asset (cash or other liquid asset, real or personal property) which a person owns and can use to meet his or her needs for food, clothing and shelter. This concept is consistent with the goal of the program to provide a minimum level of income to help meet a person's basic living needs.

The Alaskan limited entry fishing permit is a resource that has a marketable value and can be sold readily. The same basic rule applies to fishing permits as to any other item which meets the SSI definition of resources. We have done an in depth analysis of the policy dealing with the treatment of these permits and have determined that the Secretary does not have the statutory authority to exclude or redefine resources to meet the special needs and circumstances peculiar to a given group. Therefore, it is apparent that the type of relief which is being sought for Native Alaskans would have to come through legislative changes.

SUPPLEMENTAL SECURITY INCOME/FEDERAL FISCAL LIABILITY

Question: Many States choose to supplement Federal Supplemental Security Income payments to the elderly, blind and disabled with their own money. The SSI program is administered entirely by the Federal Government, and when the Federal Government makes an erroneous payment, State supplementation money is misspent at the same time.

When the Federal error rate exceeds 4 percent, the Federal Government is bound to reimburse States for erroneous supplementation payments. This reimbursement to States for misspent SSI funds is called the "Federal Fiscal Liability".

In FY 81, the estimate for Federal fiscal liability increased from $4 million to $47 million. What is the latest estimate of the error rate in SSI?

Answer: The actual national SSI payment error rate for the October 1979 through March 1980 sample period was 5.0 percent. The sample review for the April 1980 through September 1980 period is incomplete. We estimate the final SSI payment error rate also will be about 5.0 percent.

Our error rate goals are to achieve a 4.5 percent payment error rate for FY 1981 and 4.0 percent for FY 1982.

Question: How is Federal Fiscal Liability calculated?

Answer: Computations of Federal Fiscal Liability (FFL) are a byproduct of the ongoing 6-month sample of SSA's payments to SSI beneficiaries in a given State. FFL protection under the regulations excludes federally-administered "mandatory only" supplements. FFL for optional supplementation erroneously paid on behalf of States is calculated as follows: A sample payment error rate is calculated for each State by dividing the total sample payments in error by the total payments for all cases sampled for the same 6-month sample period. The payment error rate is carried to four decimal places. If the payment error rate is less than or equal to the 4 percent target error rate, beginning in October 1979, SSA incurs no liability and the net FFL automatically becomes zero.

For those States whose sample payment error rate exceeds the tolerance level, additional computations are necessary to determine if SSA is liable and, if so, the precise amount of FFL. First the results of the samples are projected to all payments made on behalf of the State to compute total dollars paid in error during the sample period. This latter amount is subject to three reductions to determine FFL.

- The amount of erroneous payments which are tolerated (target error rate times the total of all actual State supplement payments).
- The amount of erroneous payments which were recovered and already credited to the State.
- The amount of erroneous payments already absorbed by SSA under the hold-harmless provision, if any.

The net result equals the amount of FFL for a particular State for the sample period. This same concept is applied to the State of Montana. However, since it is classified as a group rate State, the sample payment error rate is determined by combining the sample results of all States. Thereafter, the computations are similar. The sum of the amounts thus computed for each State produces the national total for the given time period.

Question: In which States are the error rates highest?

Answer: There were four States with FFL payment error rates at or above 7 percent during the October 1979 through March 1980 sample review period. These States were Delaware (12.80 percent), Nevada (8.15 percent), Washington (7.60 percent) and California (7.23 percent). Complete data for subsequent periods are not yet available.

Question: What steps are being taken to improve the error rate? Please be specific.

Answer: SSA is continuing to improve payment accuracy by locating and terminating ineligible recipients and correcting benefits being paid incorrectly to eligible beneficiaries. Past efforts will be supplemented with the following new initiatives:

- Bank Account Verification Interface with the Internal Revenue Service (IRS)--SSA plans to develop a fully automated procedure in which the account numbers of SSI applicants and beneficiaries would be provided to IRS to obtain IRS data which will identify bank accounts of SSI applicants and beneficiaries.
- Preeffectuation Review--SSA will review a sample of disability cases after a State determines the claimant is disabled, but before SSA begins paying benefits.

These combined initiatives should enable us to reduce incorrect payments, improve the integrity of our disability determinations and achieve our target error rate of 4 percent in 1982.

SUPPLEMENTAL SECURITY INCOME/GAO REPORT ON ASSETS

Question: In a recent report, the General Accounting Office (GAO) asserted that millions of dollars in SSI funds were overpaid because the Social Security Administration had incomplete information about the assets (e.g., bank accounts or real property) of SSI recipients. Does the Social Security Administration agree with this GAO assessment?

Answer: We agree with the GAO assessment. A recent SSA report shows that for the 6-month period Octover 1979 - March 1980, erroneously paid dollars related to bank account ownership were projected to be $49.3 million. Real property ownership (other than the home) accounts for approximately $10 million in erroneously paid SSI dollars for the same period.

Question: What steps is SSA taking to improve its methods for monitoring the assets of SSI recipients?

Answer: The Social Security Administration is aggressively pursuing implementation of the GAO recommendation to access interest and dividend income information reported by banks and other financial organizations to the Internal Revenue Service (IRS). Use of this taxpayer information to better identify bank account owners among SSI recipients is expected to generate a significant portion of the SSI program savings in President Reagan's 1982 Budget revisions.

Additionally, the application used to determine this initial eligibility of SSI applicants has been redesigned and approved by the Office of Management and Budget. Implementation of the redesigned application form is scheduled for June 1, 1981. Specific, rather than general, questions regarding the ownership of liquid resources, especially bank accounts, will be directed to applicants, knowingly or through oversight, regarding ownership of liquid resources.

Furthermore, Social Security's Office of Assessment recently provided the results of a 1980 study conducted to determine the effectiveness of current developmental procedures relative to bank account ownership. Recommendations for modification of the procedures are currently undergoing analysis and evaluation. Once the analysis and evaluation is completed, modifications to bank account development procedures may be made.

We are addressing the issue of real property ownership through the revised application previously mentioned and through a restructuring of the basic claims representative training course to emphasize the need to identify real property ownership. The revised application will ask specific questions regarding the ownership of home property, cemetery lots or crypts, life estates or heir property, and other real property. The restructured training course should be available for use in June 1981.

ORGANIZATION AND ADMINISTRATION

Question: A former Assistant SSA Commissioner for Administration, Jack S. Futterman, recently completed a report for the National Commission on Social Security which described SSA an "an ailing mechanism for the administration of the Social Security programs." Mr. Futterman is very critical of the Agency's current organizational structure, which he says has 23 different executives reporting to the Commissioner, no focus on programs, too many opportunities for intercomponent conflict, and insufficient support in central offices for the field operations. Morale is reported to be at an all-time low throughout the agency. The report recommends that certain changes be made in the agency's organizational structure short of another radical reorganization. What is your response to this critique?

Answer: We have a great deal of respect for Mr. Futterman's knowledge, experience and ability and read his report with much interest. His comments regarding our experience with the current organization underscore the fact that the reorganization was far reaching and required realignment of large numbers of employees into new organizations and positions. Changes of this magnitude coupled with our desire to eliminate duplication created many uncertainties. For a brief period of time, some employees were not certain where they fit in the new functional alignment or if their jobs might be eliminated. These uncertainties have greatly dissipated as the new structure has become operational.

Additionally, as we have gained experience with the new structure we have been able to make it work more effectively. However, I believe the Commissioner designate will want to review this matter shortly after he is confirmed.

Mr. Futterman's conclusion, in August 1980, that staff morale was low was correct. Whether morale could be characterized as being at "an all time low" is difficult to say. In large measure, morale of SSA employees is a combination of many complex factors. The public and political leaders' attitudes toward Government employees generally, the public's apprehension about social security financing, the very complex set of social security laws and programs, and the new personnel systems established by the Civil Service Reform Act all impacted on SSA employees. Add to these factors, an inflation rate that outstrips Federal wage increases, periodic freezes on hiring and equipment purchases as well as the reorganizations cited in Mr. Futterman's report, rapid turnover of SSA's top leadership and the causes for low morale become clearer. Since 1980, we have taken a number of actions to improve this situation. We have now placed all employees in regular positions without a reduction in force or lowering anyone's grade. We are also on the road towards revitalizing and vastly improving both technical and professional training. We have installed a new appraisal system for mid-level and above managers and, while it will take several more years to perfect, we have made significant progress. We are also in the final stages of an SSA-wide planning process which will tie together in one location all programmatic, operational and legislative planning activities.

I believe that these efforts coupled with other adjustments planned for the next few months will continue to improve both morale and performance. The important point in all of this is that SSA employees will continue to carry out their responsibilities in a very effective way. Processing times, accuracy and overall quality of our service to the public has improved and we are confident that this trend will continue.

Question: How do you respond to Mr. Futterman's specific suggestions for correcting some of SSA's administrative problems, such as making the Deputy Commissioner for Operations line manager over all operations components; merging the Office of Assessment and the Office of Program Policy and Procedures, and giving the Office of Systems a larger role in systems development?

Answer: We have concluded that we do need to establish a method in headquarters to provide for more support and focus for field operations. We also are considering how to increase the Office of Systems' role in systems development. However, our immediate task in the systems area requires us to concentrate on improving both hardware and software capabilities and we have been devoting considerable resources toward this end. While we do not believe that a major reorganization is needed, we anticipate making adjustments in the months ahead. A major need for our staff is for stability and for an environment which promotes personal identification with the SSA mission. We believe that the professionalization of our career managers, the streamlining of our operations, and enhancing communications up and down the organizational hierarchy will lead to an even greater improvement in performance.

SOUNDNESS OF SOCIAL SECURITY SYSTEM

Question: It is superfluous to say that a very real concern of most Americans is their fear for the soundness of the social security system. Some of the problems the system faces are short term; many are long range. It is currently estimated that there might be severe cash-flow problems in the social security trust funds sometime in 1982. What steps is the Administration planning to take to relieve these difficulties?

Answer: President Reagan is committed to act as quickly as possible to deal with the financing problems of social security. The President's proposed economic program of budget and tax reductions is designed to restore health to the economy, and, in so doing, will go a long way toward restoring the base on which the soundness of social security financing rests. Moreover, the Secretary of Health and Human Services has established a working group within the Department to conduct an indepth, comprehensive review of all aspects of social security financing. This review will encompass the broad range of recommendations offered by various advisory councils and commissions that have examined the financing of the social security system. Despite the complexity of this task, the Administration is committed to the development of a program to address both current and future social security financing problems at the earliest possible date, and intends to have legislative recommendations ready for consideration by the Congress this spring.

OVERALL SOUNDNESS

Question: Many people believe that the worst problem the social security system faces is how it will remain solvent when the present "baby boom" generation reaches retirement age. What long-term reforms of the social security system does the Reagan Administration envisage in order to ensure its viability?

Answer: The Secretary has pledged that restoration of the integrity of the social security trust funds will be given the highest priority by the Department of Health and Human Services. The working group recently set up within the Department is reviewing all options as it develops a program to deal with the short-range and the long-range financing problems.

Question: In the short or long-term, do you foresee the possibility that social security payroll taxes could be reduced?

Answer: It would be desirable to seek a reduction in the social security payroll tax if this could be done while meeting the overriding need to restore the financial soundness of the trust funds. The working group is studying ways in which the program might be adequately financed without raising-- the scheduled social security tax rates.

LONG-RANGE, FUNDAMENTAL REFORM

Question: One suggestion for reform of the social security system is to provide incentives for people to invest more in private retirement systems, (i.e., pension plans, I.R.A. accounts) so that fewer people look upon their social security check as their primary source of retirement income. What plans, if any, does the Administration have in this regard?

Answer: We agree that incentives should be provided to encourage people to build upon their social security benefits additional protection for themselves and their families through private pensions, private investments and savings, and we will be examining the many different incentives that could be provided.

Question: At present, what is your best estimate of how many retirees rely primarily on the social security system as the principal source of their support? What percent is this of the total number of social security beneficiaries from the OASI fund?

Answer: The tables below contain information about the estimated number and percentage of social security beneficiaries that rely on social security benefits as their principal source of support.

*Reliance on Social Security Benefits as a Major Source of Income

	Age 62-64	Age 65 and Over
Married Couples		
Couples receiving benefits	993,000	6,354,000
Percent whose benefit is 50% or more of income	33%	56%
Percent whose benefit is 100% of income	5%	8%
Single Persons		
Persons receiving benefits	882,000	9,659,000
Percent whose benefit is 50% or more of income	59%	72%
Percent whose benefit is 100% of income	16%	21%

*From "Current Population Survey of 1978", (SSA, OP, ORS).

COST-OF-LIVING ADJUSTMENT

Question: Recently the Senate Appropriations Committee held oversight hearings on the state of the economy and the controllability of the budget. One idea which almost all of the witnesses agreed upon was the need to control the unrestrained growth in entitlement programs as a result of indexing them to the present Consumer Price Index. Does the Reagan Administration, either during this year or in the future, plan any adjustment to the present system providing cost-of-living adjustments in entitlement programs? Why or why not? What changes does the Administration envisage?

Answer: There are many ways in which the automatic cost-of-living increases in social security might be limited. All of these would involve legislative change requiring congressional action. Some proposals that have been suggested would base the annual benefit adjustment on an alternative measure of increases in prices; other proposals would limit the amount that could be paid on the measure currently used; still others would base the increase on a combination of economic indicators.

There are many alternatives that could be considered. While not precluding the possibility of change, we would not want now to suggest that modification of the current cost of living adjustments is necessary, or to endorse any specific modification.

I should stress that it is not at all clear that a change along these lines would be necessary or desirable. As you know, the Administration is recommending changes in economic policy that are designed to curb inflation generally and improve our overall economic situation. When economic conditions are more normal, the automatic adjustments will not be as much of an issue.

IMPROVEMENT OF AUTOMATIC DATA PROCESSING (ADP) SYSTEMS--GAO REPORTS

Question: The General Accounting Office has issued a series of reports that are very critical of the way in which the Social Security Administration has undertaken a major redesign of its Automatic Data Processing (ADP) systems. GAO charges that the redesign lacked sound planning and management, and that as a result of this inefficiency, this major and expensive initiative has yielded far fewer program and service improvements than it otherwise might have. What is the Social Security Administration's response to these criticisms?

Answer: Although it was not problem--free, the redesign was responsible for a large number of operational improvements to SSA's ADP systems. In most cases, the automated process developed by the Redesign produces far greater payment accuracy than the manual process it replaced. We agree, however, that the Redesign project showed the need for more cooperation between developers, planners and users and tighter management controls over the process.

Question: What steps is SSA taking to comply with GAO recommendations for program improvements?

Answer: There were a good many recommendations in the GAO report, most of which SSA already has taken steps to implement. To improve overall management controls over systems design work, we have established an ADP Steering Committee, a User Systems Support Plan and an ADP Strategic Systems Plan. These mechanisms now set management priorities for the Agency's ADP work. SSA has also developed several control systems for developing, modifying and implementing ADP programs. Through the use of these controls we are now ranking the demands made on ADP resources; controlling the expenditure of these resources; and ensuring that the resources are used successfully and efficiently.

Question: Since the beginning of this project in 1977, how much has been spent on the ADP redesign project:

Answer: The RSDHI Redesign Project actually ran from 1977 through 1978. It is estimated that $850,000 was expended for machine time and $2.5 million was expended for staffing over the two-year period. Some of the work begun in the RSDHI Redesign Project was later carried over for completion as part of the regular work of line organizations within SSA but this work has not been specifically identified or differentiated, so cost would be difficult to pinpoint.

AFDC ERROR RATES/GAO REPORT

Question: Last year the GAO issued a report calling upon HHS to improve the quality control systems of both the regional HHS offices and State offices administering the AFDC program. This report pointed out that quality control reviews differ from State to State and region to region, and that many area offices require very little verification of an AFDC applicant's eligibility qualifications. What steps has SSA taken in response to the GAO report?

Answer: The most important step we have taken is to issue mandatory uniform verification standards to replace the earlier guidelines. The new standards, which will be used by both State and Federal QC reviewers, define specifically which elements must be verified, how they can be verified and what sources are to be used. We believe that these standards will assure consistent findings among independent Federal/State QC reviewers because findings will be based on the same criteria. In addition, SSA has been conducting on-site assessments of each of the 10 regional QC operations to assure consistency among Federal QC reviewers.

Question: What kind of verification is presently required of an AFDC beneficiary's income and assets?

Answer: The criteria for verification are prescribed in detail in the AFDC QC manual. These criteria specify the primary and, in come cases, the secondary sources which must be reviewed for a variety of elements including:

- assignments of support rights;
- resources including real property, bank deposits, and stocks or bonds;
- earned income;
- earned income disregards including work incentive exemption, mandatory payroll deductions, work-related expenses and child care expenses; and
- unearned income including retirement, survivors, and disability benefits, unemployment compensation and workman's compensation.

Question: Does SSA have the legal authority to require standard verification procedures for all States?

Answer: Yes, SSA has the authority to prescribe the policies and procedures governing the quality control process.

AFDC ERROR RATES

Question: The budget justification for the Social Security Administration states that most States will not attain the reduced error rates set out by the "Michel Amendment", and that consequently fiscal sanctions of roughly $98 million may be imposed against certain States. What are the principal difficulties States are having in meeting error rate targets set by the Federal Government?

Answer: There are many factors that affect a State's ability to achieve its error rate target. Some of these factors are:

- Economic conditions in the State (this affects caseload size, the level of resources for administering the program, and perhaps recipient behavior).
- The degree of complexity of the various responsibilities assigned to the welfare agency.
- Quantity and quality of personnel and computer resources available to the welfare agency.

Nine of the eleven States experienced difficulty with procedural eligibility requirements specified in the statute, i.e., the requirements that recipients have or apply for an SSN, that they assign their child support rights to the State, and that they register for WIN. Other major causes of errors are client failure to report outside income or bank accounts and agency failure to act upon available information.

Question: What steps is SSA taking to help States meet these targets?

Answer: SSA is taking action to help the States meet their QC targets by:

- Working closely with States in the analysis of QC and related data in order to develop with each State a corrective plan of management action addressed to sources and causes of errors. The implementation of these corrective action plans of States is monitored through regular meetings with State agency officials, periodic progress reports submitted by the States and technical assistance on management techniques and approaches useful in corrective action plans.
- Working on a revision of Federal regulations concerned with eligibility redeterminations, fraud, recoupment and enumeration in order to strengthen and clarify Federal policy guidance for States in these areas which are frequently sources of QC errors. Consultation and training continue to be provided to States on monthly reporting and retrospective budgeting.
- Intensifying technical assistance efforts to States in developing increased computer capability. This capability in States will facilitate computer data matching of welfare rolls with numerous other information systems in both private and governmental programs in order to strengthen State efforts for verification of eligibility of recipients. Computer capability will also enable States to develop; error prone profiles, client information systems, improved eligibility determination systems, and case monitoring and management systems.
- Conducting, in selected States, intensive management reviews of State agency operations and accelerating efforts to guide States in the development and implementation of training programs for eligibility workers, supervisors and managers.
- Arranging for technology transfers from one State to another of effective management practices, providing management improvement

materials requested by States (in a recent 12 month period: 250 requests for 750 different documents), and issuing major publications and a quarterly newsletter. Within the next 3 months, State and local welfare administrators will be brought together in 2 conferences for the purpose of sharing and learning from one another on such subjects as:

--manager and local offices performance accountability;

--improve processes for eligibility redetermination, verification procedures, recoupment of overpayments and tracking systems; and

--increasing the productivity of staff and the effectiveness of supervisory-management systems.

Question: For the record, please provide a list of all the States and their AFDC error rates.

Answer: The AFDC error rates for the April - September 1979 sample period are as follows:

State	April-September 1979
U.S. Average (weighted)	9.5
Alabama	6.8
Alaska	16.5
Arizona	6.9
Arkansas	10.6
California	7.8
Colorado	6.3
Connecticut	6.3
Delaware	12.5
Dist. of Col	19.1
Florida	4.1
Georgia	6.6
Hawaii	8.0
Idaho	7.5
Illinois	11.9
Indiana	4.2
Iowa	6.4
Kansas	3.9
Kentucky	6.9
Louisiana	7.[illegible]
Maine	10.2
Maryland	13.6
Massachusetts	22.4
Michigan	9.6
Minnesota	3.7
Mississippi	9.4
Missouri	8.9
Montana	14.8
Nebraska	2.4
Nebada	2.3
New Hampshire	17.2
New Jersey	11.8
New Mexico	7.4
New York	8.8
North Carolina	6.3
North Dakota	6.1
Ohio	9.1
Oklahoma	5.5
Oregon	9.4
Pennsylvania	9.7
Puerto Rico	7.1
Rhode Island	7.6
South Carolina	5.5
South Dakota	3.5
Tennessee	6.4
Texas	7.0
Utah	6.5
Vermont	15.2

State	April-September 1979
Virgin Islands	9.9
Virginia	7.3
Washington	6.5
West Virginia	6.3
Wisconsin	13.5
Wyoming	12.4

TEENAGE PREGNANCIES AND AFDC CASELOAD

Question: Teenagers who bear children are often dependent on Federal, State and local assistance for support. What percentage of the AFDC caseload is made up of teenage mothers and their children? Is this population increasing or decreasing?

Answer: Based on data obtained from the biennial AFDC Recipient Characteristics Study, an estimated 232,781 families or 6.8 percent of the total AFDC caseload in 1979 included a teenage mother in the assistance unit. The number of AFDC families with a teenage mother present increased during the decade of the 1970's, from an estimated 107,600 cases in 1969 to a peak of 260,123 cases in 1977. As a percentage of all AFDC families, teenage mothers accounted for 6.6 percent of the total AFDC caseload in 1969. By 1973 the percentage had grown to 7.6 percent and began to drop after 1975. The table below presents the data from which this information was derived.

FDC FAMILIES WITH TEEN-AGE MOTHER PRESENT

Year	Total AFDC families	Number of teen-age mothers	Percent of total families
1979	3,431,491	232,791	6.8
1977	3,523,294	260,123	7.4
1975	3,418,671	258,503	7.6
1973	2,989,891	226,495	7.6
1971	2,532,900	182,000	7.2
1969	1,630,500	107,600	6.6

ASSISTANCE PAYMENTS / ADVANCE APPROPRIATION

Question: This year, the Social Security Administration has for the first time requested an advance appropriation for the assistance payments account. What is the advantage of an advance appropriation for FY 1983, as opposed to the old system which allowed borrowing from a future appropriation?

Answer: There are two major advantages to this approach when compared with borrowing from a future appropriation -- increased specificity in the amount of funding needed for advanced grants and clarity of presentation.

Increased Specificity

By formalizing the request for funds for the first quarter of fiscal year 1983 advanced grants in lieu of borrowing funds for that quarter, Congress is afforded the opportunity to review the program estimates and their justification in an easier to understand format. This will allow Congress to specifically approve or modify funding for the first quarter of 1983. In addition, these funds will count towards the 1983 versus 1982 budget target.

Clarity of Presentation

The elimination of the borrowing for first quarter grants obviates the need for the adjustment in the budget year estimates caused by the borrowing for advance grants. After fiscal year 1982, the conversion year, the budget authority, program costs, and obligations for a given budget year will be the same, thus eliminating past problems in presenting and understanding the differences between these items.

ASSISTANCE PAYMENTS/RESEARCH AND DEMONSTRATIONS

Question: Please discuss ways in which any of the work carried out with Assistance Payment Research and Demonstration money has improved the administration of the AFDC or Child Support Enforcement Program. Cite specific examples.

Answer: Funds and waivers of the Assistance Payment Research and Development Program have improved the administration of the AFDC and Child Support Enforcement program by (1) demonstrating new technologies to reduce personnel costs, (2) developing more cost-efficient program structures and delivery procedures and (3) developing better evaluation measures. Examples of these projects in the AFDC program include:

- Demonstrations of retrospective accounting periods and mandatory income reporting. Colorado has tested altering the accounting period for AFDC benefits from the prospective month to the retrospective month. This and similar projects ongoing in Illinois and Michigan are expected to reduce program costs by reducing the amounts of unreported earnings by AFDC recipients and by cutting down the number of related errors.

- South Carolina, West Virginia, Texas, and other States are developing profiles of cases that are most error prone so that more frequent redeterminations can be conducted in the most cost-effective way.

- A contract has been used to evaluate the effect of corrective actions and pinpointed those that are most effective for States to use.

- A project in New York developed and tested a system for using decision logic tables to assist the caseworker in avoiding errors in eligibility and redetermination actions.

- Massachusetts has developed an improved system to recoup funds that were incorrectly provided to recipients.

The following are examples of projects to improve the administration of the child support enforcement program:

- Several grants have been made to assess the functioning of court systems via a vis the child support enforcement program in order to increase support payments.

- A grant was made to assess possible savings which might be achieved from including health care coverage from the absent spouse to the child and thereby save in the Medicaid program.

- A contract was let to design and test a model system for collecting support payments when the parents live in separate States.

- A demonstration in Massachusetts will test the desirability of using wage assignments to collect child support amounts and the amount of savings expected to result. The method should improve the regularity with which payments are received by AFDC mothers.

- A demonstration in New York looked at the cost effectiveness of using police to serve warrants on absent fathers who have not regularly paid their child support amounts. It is expected that this device will increase compliance and welfare savings.

LOW INCOME ENERGY ASSISTANCE PROGRAM/STATE ADMINISTRATION

Question: Reports in the press indicated that the administration of the Low Income Energy Assistance Program (LIEAP) has been uneven. Some States appear to pass along money to the needy for heating costs smoothly and efficently; others process claims very slowly. What actions has HHS been taking to help States administer this program efficiently?

Answer: The administration of the LIEAP program varies from State to State. As a result, some States are slower than others in delivering assistance. Flexibility in designing administrative procedures, including the rate at which applications are processed, is one of the important elements of the block grant nature of LIEAP.

The Federal Government has responsibility for monitoring State LIEAP administration, but only to the extent to determine if State programs are in compliance with the authorizing statute, with regulations and with the State's own plan for LIEAP and to assist the State in making changes, if necessary. Regulations require that States determine whether or not a household is eligible within 45 days of application. However, States have the freedom, under this Act, to set their own standard for when assistance will actually be delivered.

HHS assisted States to administer their program effectively in the following ways:

- o Published interim regulations 57 days after authorizing legislation was signed and final regulations 6 days after appropriation;
- o sponsored a conference in June 1980 for State and Federal officials to help States understand the legislation and regulations;
- o provided data on energy consumption and costs needed to assist States in computing benefit levels for eligible households;
- o assisted States in developing their operational systems for application processing, data collection and reporting, calculating assistance levels for eligible households, including renters and tenants of public housing;
- o assited States in setting up their monitoring systems and provided feedback as a result of HHS monitoring of State programs;
- o responded with approvals of State plans on an average of 30 days after submission and presently prepared to respond quickly to amendments; and
- o make technical assistance available, upon request to any State experiencing difficulty with its program administration.

Question: For the record, explain what steps States need to take before HHS releases these funds.

Answer: HHS awards funds to States for LIEAP after the plan for energy assistance is approved. Upon approval, the State must request funds in accordance with its estimated projection of expenditures and must follow Federal requirements for the administration of grants to States.

LOW INCOME ENERGY PROGRAM/TARGETING ON NEED

Question: The cost of heating a home in winter continues to rise at a very quick pace. Yet, to date there has not been a study defining how great a need there is for low income energy assistance and where the need is located. Does HHS plan any study to accurately define the need for this kind of assistance?

Answer: HHS has worked with the Department of Energy to expand the Residential Energy Consumption Survey to include a greater number of low income households. Data from this survey will identify the energy burden of low income households nationwide and allow us to analyze the need for assistance. Results from the survey will be available by the end of 1982.

Question: To what extent do you believe the present system fails to target resources on the most needy?

Answer: The current program mandates that the States must pay the highest benefits to those with the lowest income and highest energy costs. In addition, outreach efforts must focus on the aged and the handicapped. However, income is only one variable in determining need for energy assistance. Geographic location, annual weather patterns, and type of fuel must also be considered in determining need. The States are in the best position to decide which factors are most important and they have flexibility within the constraints just mentioned to tailor assistance to local needs. The block grant approach proposed for 1982 will allow the States even greater flexibility to provide both on-going and emergency assistance.

LOW-INCOME ENERGY PROGRAM

Question: It has been suggested that more and more households will have trouble affording the price of keeping warm in winter as the result of the decontrol of oil prices and the proposed decontrol of natural gas. Does the Administration intend to request the reauthorization of the low-income energy program?

Answer: We do not plan to request reauthorization of the low-income energy program in its present form. In its place, we propose to consolidate its function with that of the emergency assistance program authorized by title IV-A of the Social Security Act, and establish a block grant authority to the States for providing energy and emergency assistance to needy households. Under our proposal, the funds could be used to assist households in meeting home energy needs, to provide cash or in-kind assistance for emergency situations, for emergency medical care or social services, and other similar uses as the States deem appropriate. The States will have broad discretion in all aspects of the program.

Question: Does the Administration foresee major changes in the structure of the program?

Answer: The program's block-grant structure will be continued. Under our proposal, States will have increased flexibility in developing their programs including making such decisions as to use of funds, the population eligible for coferage, the types and forms of assistance provided, and levels of payments. Thus, each State will be able to design a program that can best respond to its own particular conditions and needs.

We expect that States will build on the experience gained in administering the past 2 years' programs to create a more efficient program, within whatever State structure they find more effective.

Question: Since the Windfall Profits Tax specifically earmarks part of its revenues to pay for home heating costs, will the Administration continue to set aside a part of these revenues for this purpose?

Answer: No trust fund was actually established from the Windfall Profits Tax revenues. Last year's program was funded by the Congress through the normal appropriations process.

We do not propose to reestablish a tie between the two programs. Our proposed block grant would be funded from general revenues.

SURVEY OF INCOME AND PROGRAM PARTICIPATION (SIPP)

Question: For the past 2 fiscal years, the Carter Administration requested funds to begin the Survey of Income and Program Participation, a social research survey designed to gather data on program eligibility on a broad range of government income security programs. Does the Reagan Administration feel it would be worthwhile to conduct such a survey? Why?

Answer: The revised Reagan budget includes funding to conduct the Survey of Income and Program Participation. The Reagan budget provides budget authority in FY 1982 of $8,000,000 to cover expected obligations in FY 1982 in the same amount. In contrast the Carter budget provided $15,000,000 in FY 1982 budget authority to cover the full cost of the first two year survey.

The survey will provide a research and data gathering mechanism that will assist the Administration in developing and assessing new legislative and administrative initiatives and to respond to questions or proposals from Congress.

Among the social welfare expenditure questions for which the survey will provide answers are the following:

- What is the impact of current programs on individuals and families, and especially the joint receipt of benefits from various government income security programs (e.g., SSI, Food Stamps, etc.)? Is the combined level of assistance appropriate?
- What are the gaps between eligibility for and participation in current programs, especially as it regards individual and family characteristics and needs? Is assistance allocated equitably?

- What will be the impact (winners and losers) of program changes or shifts in eligibility rules and benefit schedules? Can we make more efficient use of resources?

- What are the circumstances and dynamics of shifting between benefit status, employment, and changes in household composition? Is it likely that changes in employment or income security programs could moderate some of these shifts?

The present sources of data have limitations in providing answers to such questions. The extensive revisions required to make these other surveys good sources of program and income data would interfere with their success in achieving their primary purposes and could not be even attempted without substantial increases in staffing and funding to meet this increased responsibility.

OFFICE OF REFUGEE RESETTLEMENT

STATEMENT OF WILFORD J. FORBUSH, ACTING DEPUTY UNDER SECRETARY FOR SPECIAL PROJECTS AND DIRECTOR, CUBAN-HAITIAN TASK FORCE

ACCOMPANIED BY:

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ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET

SUBCOMMITTEE PROCEDURE

Senator CHILES. We now turn to the subject of assistance to the State and local governments for the costs incurred by the large inflows of refugees. I think it's important to point out that we are mostly not talking about providing extra benefits to refugees. Once Federal policy lets a large group of refugees in, then the cost for education, welfare, medicaid, and social services are going to be incurred. What we are talking about is who bears the cost. While I'm all for cutting back the budget, I think one area where the Federal responsibility is clear is when a President says he will welcome people in with open arms and if he refuses to do anything to keep boatloads from coming in, then it's the Federal Government causing these expenses and it should be the Federal Government that reimburses the State and local government for those expenses. The local communities still have to deal with the social problems of assimilating the group, and when we talk about 150,000 or 160,000 people coming into Florida, that's equivalent to adding one-fourth of the population of Boston or the District of Columbia in just a few months. We can't solve the social problems at the Federal level, but at least we can avoid the financial burdens or placing those burdens on top of the social ones.

With that, we will turn to our witnesses who will be Mr. Wilford Forbush and Mr. Roger Winter, and if you would intro-duce your colleagues to us we would proceed with your testimony.

INTRODUCTION OF ASSOCIATES

Mr. FORBUSH. Thank you, Mr. Chairman. Roger Winter is on my left and John Hopkins from the Budget Office is on his left. To my right is John Cannon, the Assistant Director for Operations of the Cuban-Haitian Task Force, and then Larry Silver from the National Institute of

Mental Health who's in charge of the mental health activities of the refugee program. To his right is the perennial witness, Tony Itteilag.

PREPARED STATEMENT

Senator CHILES. Will you proceed then, and your statement in full will be placed in the record.

[The statement follows:]

STATEMENT OF WILFORD J. FORBUSH

Mr. Chairman, members of the subcommittee, I am pleased to have the opportunity today to discuss the refugee resettlement programs of the Department of Health and Human Services.

Last year the Congress enacted the Refugee Act of 1980 which for the first time established a permanent U.S. policy towards refugees and a program of resettlement assistance. The law established the Office of Refugee Resettlement (ORR) within the Department of Health and Human Services and authorized it to encourage and enable refugees to become economically self-sufficient as soon as possible. The Department manages these programs in consultation with the United States Coordinator for Refugee Affairs.

The Refugee Assistance program is designed to assimilate refugees into American society as quickly and effectively as possible while minimizing the burden to States and localities. The program provides direct cash and medical assistance to needy refugees as well as English language training, vocational training and other social services. Eligibility for this special Federal assistance is based on States' assessment of refugees' needs and the likelihood that they will benefit from social services. All of these activities help to ease refugees' adjustment to American society and to allow them to become independent and self-sufficient.

In addition to our programs for refugees, the Department provides similar services to the Cuban and Haitian "entrants" who arrived on our shores in substantial numbers last June. We are now phasing down our emergency activities for these individuals and integrating continuing activities for entrants into the regular refugee program.

The overall resettlement program has greater international implications than do most other domestic programs. In fact, domestic resettlement is most clearly understood as the consequence of this nation's foreign policy decisions as to the number of refugees admitted each year. This foreign policy decision has a direct impact on local communities and on the Federal budget for this program. In FY 1981, we estimate that over 200,000 refugees will be admitted to the United States.

REFUGEE ASSISTANCE PROGRAMS

There are five parts to our refugee assistance programs for FY 1981: State Administered Programs, Voluntary Agency Programs, Education Assistance for Children, Federal Administration and Preventive Health.

a. State Administered Programs

These programs include cash and medical assistance, social services, State administrative costs for the regular refugee program, and the Cuban Program Phasedown.

The Cuban Program Phasedown is the last piece of a domestic assistance program authorized under the Migration and Refugee Assistance Act of 1962, to provide domestic assistance to Cuban refugees who entered the U.S. prior to October 1, 1978. The Refugee Act of 1980 mandates that this program be phased out over several years. The budget authority for FY 1981 is $44.8 million.

The rest of the State administered programs provide funds to State agencies to pay costs for cash assistance, medical assistance, English language training, vocational training, employment counseling, and a variety of other social services provided to eligible refugees. In the past, the Federal Government has reimbursed the States 100 percent for refugee costs.

In FY 1981, the budget authority for this program is $551 million. The amount of funds needed for these activities is dependent upon the number of refugees admitted to the U.S. and the percentage who will require public assistance. Current program experience suggests that the newer refugee groups lack job skills appropriate to the American economy and are less fluent in English than the refugees who arrived in 1975-78, and thus need cash and medical assistance and social services from the States in which they reside.

b. Voluntary Agency Program

This activity provides matching funds on a dollar-for-dollar basis, up to a specified maximum, to voluntary agencies who resettle Soviet and other refugees not covered by other Federal refugee programs. The principal objective is to enable the refugees to become self-supporting and independent members of American society. Most of these funds are provided for the resettlement of Soviet refugees. A wide range of activities is covered including training, recertification in the United States for professionals trained abroad, social services, maintenance assistance, and health care. In FY 1981, the budget authority for this program is $24 million.

c. Education Assistance for Children

This program provides funds to heavily impacted local educational agencies to assist annual refugee children arrivals. These funds are transferred to the Department of Education which administers the program. In FY 1981, the budget authority for this program is $44.3 million.

d. Federal Administration

The Refugee Act of 1980 established ORR to oversee domestic refugee assistance programs. The Act requires increased program monitoring and evaluation, fiscal accountability and reporting of refugee programs funds, and data collection by ORR.

e. Preventive Health

We fund two types of preventive health care for refugees. First, we screen refugees before they enter the U.S. for dangerous diseases. ORR transfers funds and positions to the Center for Disease Control to conduct the screenings overseas and at domestic ports of entry. Second, we provide direct health care through the Health Services Administration (HSA) to refugees once they have been relocated in the U.S. HSA conducts health assessments and immediate follow-up care for a variety of special health conditions of refugees. In FY 1981, our budget authority for these activities in $7.86 million.

CUBAN AND HAITIAN ENTRANTS PROGRAM

There are two major parts to this program: domestic assistance, and reception and processing.

a. Cuban and Haitian Domestic Assistance

Our program for domestic assistance to Cuban and Haitian Entrants is authorized by Title V of the Refugee Education Assistance Act of 1980. The program has the following components: cash and medical assistance and related State administrative costs, social services, unaccompanied minors, and Federal administration.

During fiscal year 1981 we expect about half of the 150,000 Cuban and Haitian entrants to receive cash and medical assistance. For up to three years after the entrant arrives in the U.S. the Federal Government is authorized to pay the full cost of this assistance. To date the Department has made grants to States to cover estimated costs for the first two quarters of fiscal year 1981.

This program also provides grants to States to provide social services -- especially English language training and job skills -- and the costs of caring for unaccompanied minors. As a condition for receiving benefits, a State must agree to exercise parental responsibility for the unaccompanied minors who have been resettled within its jurisdiction. We in turn will pay for the child welfare costs of the unaccompanied minor until age 18.

b. Cuban and Haitian Reception and Processing

Currently we are attempting to close out the activities launched last summer to meet the influx of 150,000 Cubans and Haitians. There are about 4,000 Cubans still in the Fort Chaffee resettlement camp. We are working with Voluntary Agencies, Hispanic self-help groups, and State and local governments to find appropriate sponsors for these people as quickly as possible. For entrants with extraordinary adjustment problems, we are funding group homes to assist them through the transition. Entrants with severe mental health problems will remain in Federal custody until they can function independently in society. We are attempting to make arrangements with non-Federal mental health care groups to provide an appropriate therapeutic program for these entrants with the full costs of the care to be provided by this program.

Currently Haitians are entering the country at a rate of approximately 100 per week. While they are awaiting appropriate review by the Immigration and Naturalization Service and the State Department, we are working with Voluntary Agencies and other groups to settle them with community sponsors. We also stand ready to activate the resettlement camp at Fort Allen, Puerto Rico. However, the utilization of this facility is currently the subject of court action which restrains us from using the camp at this time.

REGULATIONS

With the enactment of the Refugee Act of 1980, it is necessary for the Department to develop regulations for the refugee program in accordance with the requirements of the Administrative Procedures Act. These regulations will codify existing program instructions for the refugee program and will outline State responsibilities for participating in the program.

However, no State or other agency or organization is required to participate in the refugee program, and the regulations do not affect non-participants.

A regulation on "Plan and Reporting Requirements for States" was issued September 9, 1980, in order to meet an October 1, 1980 deadline specified in the Refugee Act. This regulation outlined the basic requirements for State participation. The Department is now developing a more comprehensive regulation which will cover all major aspects of the refugee program, including refugee cash and medical assistance, social services, child welfare services, general administration, and Federal financial participation.

The development of regulations will require approximately two staff work-years in 1981 at an estimated cost of $100,000. The regulations will not require any additional ongoing administrative cost for the refugee program.

I wish to thank you for the opportunity to address this subcommittee. I am prepared to respond to any questions that you may have at this time.

CURRICULUM VITAE

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Superior Service Award, HEW - October 1970
Secretary's Special Citation - January 1973
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Secretary's Special Citation - January 1977
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SES Meritorious Executive, Presidential Rank, October 1980

WORK EXPERIENCE:

December 1980 to Present	- Acting Deputy Under Secretary for Special Projects and Director of the Cuban-Haitian Task Force, Office of the Secretary, HHS
May 1979 to December 1980	- Deputy Assistant Secretary, Policy Coordination - Office of the Assistant Secretary for Management and Budget, HEW until May 1980; thereafter Department of Health and Human Services
June 1974 to May 1979	- Deputy Assistant Secretary, Budget, Office of the Assistant Secretary, Comptroller, HEW, changed to Assistant Secretary for Management and Budget in 1977
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OVERVIEW

Mr. FORBUSH. I will just give you a brief overview of this network of programs.

The Department of HEW which preceded HHS has been involved in refugee programs for many years. It began in 1959 with the first Cuban refugee activity. There have been piecemeal things that have happened since then, particularly with the Indochinese refugees, but this patchwork quilt was replaced in March 1980 with the enactment of the Refugee Act of 1980.

ASSISTANCE TO REFUGEES

Under that act, there's a regular procedure for admitting refugees, and all refugees from across the world are treated equally. The involvement of this Department starts after a decision has been made to admit. We provide the domestic assistance once the refugee has been admitted into the United States and we resettle him into a community. The State Department and Justice Department deal with the screening of the refugee and the actual admission.

Our refugee programs mirror programs for the general population. We provide cash assistance, medical assistance, and social services. HHS reimburses the State's share of those costs for a 3-year period under the act. We also provide some special matching grants to some voluntary agencies for a special category of refugees from the Soviet Union. In addition, we provide some health screening activities in the overseas camps and once the refugee arrives here, and help the refugee to adjust to the American health care system.

CUBAN AND HAITIAN ENTRANTS

Last summer we were confronted with a special crisis from the influx of Cubans and Haitians. The initial response to that was to create an emergency administration under the direction of the Federal Emergency Management Agency. As that crisis went on, it was converted to a task force operation under the direction of the Department of State. The Department of Health and Human Services provided assistance to the State Department, but we were not in charge of managing the task force.

On November 15, the responsibility for managing the task force was transferred to the Department of Health and Human Services. By this time a special legislative authorization for handling the incoming population had been enacted, the Refugee Education Assistance Act—Public Law 96–422. Between April and November 1980 approximately 150,000 people arrived, of which 125,000 were Cubans. The peak month was the month of May when 86,000 Cubans came in as well as 1,400 Haitians.

Initially there were four entrant camps in operation, Eglin Air Force Base, Fla.; Indian Town Gap, Pa.; Fort McCoy, Wis.; and Fort Chaffee, Ark. At present we have just Fort Chaffee open and it has about just under 4,000 entrants there now.

One of the important features of the Refugee Act was an authorization to provide domestic benefits to Cuban and Haitian entrants equivalent to the benefits provided to refugees. So in effect, the Refugee Act has been reproduced for these entrants and we have initiated that program and made grants for this fiscal year.

As the crisis winds down and Fort Chaffee is closed, I believe that our organization will be changed and the separate task force will be dissolved and the remaining functions will be gradually merged into the Office of Refugee Resettlement.

Thank you. That completes my general statement.

FEDERAL RESPONSIBILITIES FOR REFUGEES AND ENTRANTS

Senator CHILES. All right, sir. I have been concerned about the way our refugee operations are organized to allow a consistent policy on refugees. It's clear that right now we really have no refugee policy.

First, tell us how the Office of Refugee Resettlement relates to the Cuban-Haitian task force? Where do your responsibilities begin and where do they end?

Mr. FORBUSH. The Cuban-Haitian task force is focused exclusively on the entry problem. Before the transfer to HHS occurred, the Department did do some work for the task force as requested by the Department of State. For example, we managed their program of unaccompanied minors. But there was a fairly clear separation of responsibility.

The distinction I think could be related back to the Fascell-Stone authorization. The task force is in charge of section 501.C of title V of the Refugee Education Assistance Act, which is reception and placement of the entrant, and the Office of Refugee Resettlement administers section 501.A, which provides for domestic assistance reimbursement to State and local governments.

When the task force was transferred to the Department we thought it would be less disruptive to operations if we kept two separate units for a while and we have done that. As the job winds down, I think the critical event is closing Fort Chaffee. As soon as Fort Chaffee is closed, you could then take the residual activities of the task force and place them in the Office of Refugee Resettlement.

ROLE OF THE IMMIGRATION AND NATURALIZATION SERVICE

Senator CHILES. Well, how do you relate to the Immigration and Naturalization Service regarding processing of applicants and the followup after sponsorship falls through?

Mr. FORBUSH. Well, the followup on the sponsorship is basically our responsibility and we try to——

Senator CHILES. Do you systematically report to somebody in INS that somebody is unattached in a community?

Mr. FORBUSH. Yes; in the typical case the voluntary agency which is the sponsor for that individual will contact us and say they have a problem on their hands. We then notify the Immigration and Naturalization Service. We try to ameliorate the problem first. If that doesn't work, INS revokes the parole and the individual is placed back in the Federal custody.

SPONSORSHIP BREAKDOWNS

Senator CHILES. We have had a number of sponsorships that seem to have been made early on in which someone sort of signed as being a family member or something to get these people I guess out of the camps. All of those people have ended up in Miami. It's not a bona fide sponsorship at all. They were down there roaming the streets.

Mr. FORBUSH. Yes, sir; unfortunately, the processing at the initial stages last summer was very sloppy in many cases. We have tried to ameliorate that in a number of ways. First the Immigration and Naturalization Service has removed from Dade County some entrants with broken sponsorships who have run afoul of the law. To date, 184 have been removed from Dade County facilities and placed into Federal facilities.

Second, we have a program of secondary resettlement operating in Bay Front Auditorium in downtown Miami. We have assisted 4,000 Cubans to relocate out of Miami through that effort.

Third, we have provided some assistance to the State of Florida for overcoming public safety problems. We awarded a grant of $3.8 million to the State a couple months ago.

Senator CHILES. Do you have any idea now of what the number of people are that are out there with broken sponsorships?

SPONSORSHIP SURVEY

Mr. FORBUSH. I'm afraid I do not have any precise data on that. We have a plan to make a survey of the sponsorships.

Senator CHILES. This is what I want to know. Are you all doing any kind of a systematic check to determine if people that went out on a sponsorship are still in that sponsorship, if that is working, or whether that was just a paper transaction and those people in fact are loose?

Mr. FORBUSH. We are not doing that for the entire population. We are doing it for a sample to get a feel for the overall picture. Our first line of defense there is the voluntary agency which claims or initiates the—works out the initial sponsorship.

Senator CHILES. Well, I don't want to be critical of the voluntary agencies because some of them did an outstanding job. Some of the voluntary agencies were paid, though, on a basis of a per head capita on the basis of their sponsorship.

Mr. FORBUSH. That's right.

Senator CHILES. And that is based on them putting the people out. It's not a continuing thing.

Mr. FORBUSH. No; it assumes they will provide some followup for at least a year after the sponsorship occurs.

Senator CHILES. But they are not going to receive any continued pay. It's a front-end load as far as what the payment is.

Mr. FORBUSH. That's correct.

Senator CHILES. So it seems to me the Federal Government ought to be doing some checking to determine if people that went out on a sponsorship are still in that sponsorship, because we still see very large numbers of refugees with no means of support, no job, sleeping in streets and under bridges and sort of roaming the streets.

Mr. FORBUSH. I think it's a smaller problem now than it was a couple of months ago, but it is still a problem. It's our intention to try to make the sponsorship work. But if that can't be done, then INS would revoke the entrant's parole, bring them back into Federal custody, and try to find a new sponsorship somewhere else.

Senator CHILES. It seems to me you immediately need to do this survey. I would like for it to be just a check rather than a survey, but maybe the survey would at least tell you what the magnitude of our problem is there.

Mr. FORBUSH. Yes.

RECENT HAITIAN ARRIVALS

Senator CHILES. One particular concern I have is how you're handling the current flow of Haitian immigrants. You said in your statement about 100 people a week are coming and that you're working to resettle them in the community. My understanding from the other side was that INS is holding the undocumented Haitians and providing an expedited hearing to see whether they should be allowed to stay.

Mr. FORBUSH. That action applies only to those who come in by air and have falsified visa documents. They are not doing that for the Haitians who arrive by boat. At present, we have managed to resettle more than have come in and we have reduced the number of Haitians held in the INS facility in Miami to under 200.

HAITIAN RESETTLEMENT

Senator CHILES. Where are you resettling them?

Mr. FORBUSH. If they have family members in the United States—and many of them do in southern Florida—they are released directly to them. However, an increased proportion of Haitians are being resettled outside of Florida. Several months ago, about 90 percent went to Florida and now it's about 40 percent.

Senator CHILES. Well, the refugee policy, as I understand it, applied to a cutoff date, to a particular date.

Mr. FORBUSH. The entrant designation?

Senator CHILES. That's right.

Mr. FORBUSH. It was October 10.

Senator CHILES. Right.

Mr. FORBUSH. And the post-October 10 people are subject to exclusion proceedings. INS is scheduling hearings for the post-October 10 arrivals, but not on the accelerated basis that they are for Haitians arriving by plane.

Senator CHILES. But you're just resettling them—if they don't come by plane, you're putting them out in the community?

Mr. FORBUSH. Yes; I think that the conditions of the INS detention centers are not adequate for long-term holding.

HAITIANS LIVING IN THE BAHAMAS

Senator CHILES. It's estimated there may be as many as 80,000 Haitians illegally in the Bahamas. What plans do you have if any or all of these Haitians attempted to leave or were expelled from the Bahamas and all or a portion of them tried to come to the United States?

Mr. FORBUSH. Well, I don't think it's realistic to expect that large a number. Estimates of Haitians facing possible deportation vary from 15,000, I suppose, up to 80,000. The government of the Bahamas had an order effective January 18 that they would start expelling people. As yet, it has not produced a huge influx.

Our basic plan, however, is to use the facilities we have at the Krome sites in Miami on a temporary basis and then open the camp at Fort Allen which we are temporarily unable to do because the Federal Government has been enjoined by the U.S. District Court in Puerto Rico from using the facility. That case is under appeal in the First Circuit Court in Boston. If we got a large influx that overloaded our facilities in Miami, I think we could get accelerated review and begin to get that camp in operation very quickly.

CONTINGENCY PLAN FOR ADDITIONAL ARRIVALS

Senator CHILES. Well, is there a plan like a plan with INS for accelerated hearings that they're making where undocumented aliens come in by air? What kind of plan will there be if we have a mass exodus from the Bahamas, 5,000 or 10,000 even?

Mr. FORBUSH. We have capacity to go up to 5,000 at Fort Allen. If it exceeds that, we would have to open yet another camp elsewhere. We do not have a specific contingency plan in place, but we are working with the State Department to try to develop one for covering both Cubans and Haitians.

Senator CHILES. Well, I think the people of Florida and south Florida would sure like to think that the Federal Government had a contingency plan for this fuse that's sitting over there ticking, and especially where you have an order now from the Bahamaian Government saying they are going to make deportations, and I can tell you that there's a tremendous concern from the people that have had the waves come in already—150,000 to 160,000 people—that here is the potential of up to 80,000 and let's say it's 5,000 or 10,000 more, you know, that would come in a wave—there's just no telling what that would do to that community down there and to know that the Federal Government doesn't have a contingency plan as to how to handle those yet.

Mr. FORBUSH. It is a priority with the new administration but it does involve some very tricky questions of law enforcement and some——

Senator CHILES. You know, when the others came in, we didn't have a plan and it's sort of like that's happened now and there were a lot of tricky questions there and we had to go through the process of all those questions, but certainly we have some experience now.

Mr. FORBUSH. Yes; I hope we can avoid that.

Senator CHILES. From the 150,000 to 160,000 that we have had in, I'd like to think that we could have a contingency plan.

REVISED BUDGET ASSUMPTIONS

Does the Reagan administration concur with the Carter budget assumption that no new Cubans or Haitian entrants will come into the United States in fiscal year 1982?

Mr. FORBUSH. I know of no proposal changes. I don't know if it will be formally ratified, but I don't think that there are any. We're required to put that in the budget and I don't see any.

Senator CHILES. What would it cost if the present flow of Haitians continued through 1982?

Mr. FORBUSH. We would assume that the cost per resettlement would be about between $500 and $1,000. So if there were another 12,000 Haitians coming in, it would cost about $12 million.

DECREASE IN CASH AND MEDICAL ASSISTANCE

Senator CHILES. Well, I'm concerned about your low estimates of the cost for the Cuban and Haitian entrants program. You show a 57-percent decrease in cash and medical assistance from 1981 to 1982. That amounts to a $49.5 million drop. The State of Florida has projected only a 10.2-percent decline in caseload over this same period. A 24-percent increase in general assistance is offset by a 28-percent increase in the aid for families with dependent children. That increase seems to occur as more people find out about welfare qualifications and as many of the young women have children.

How do you account for the discrepancy in the estimates? It looks like to me if the Florida projections are correct you would be as much as $40.6 million too low just for the cash and medical part of the program. Do you discuss the caseload estimates with the affected States when you're making up your budget?

Mr. FORBUSH. Yes, sir; we request the State to make an official estimate as part of their request for grant assistance.

Senator CHILES. So Florida gave you the figures they had in their estimates?

Mr. FORBUSH. I'm not sure they have given us the latest estimate, but they gave us some last November. I might ask Roger to fill me in on that, but I think the latest estimates from Florida haven't been received yet.

Mr. WINTER. We have estimates for the fiscal year 1981. We do not yet have and have not yet requested formally from the State of Florida any estimates for the fiscal year 1982. What we do intend to do is attempt to reassess the level of budget for fiscal year 1982 based on the actual experience in the State of Florida and in other States. The State of Florida's domestic assistance program only began on January 14, so we only have about 6 weeks of actual experience so far. As that actual experience data builds over time, we will be in a better position to know whether their current estimates or our current budgetary estimates are accurate.

Senator CHILES. Well, I notice that the Carter budget went from $87,200,000 to $37,700,000, and now we're hearing that the Reagan budget is going to go lower than that.

What's the basis of having that tremendous decrease?

Mr. FORBUSH. The entire question revolves around the percentage of this new population which will be dependent, which will be out of work and not be able to have another source of income.

I think what we see here is the Federal Government has estimated perhaps a bit on the low side, but I think the State government has estimated way on the high side. I think you have to follow what is actually happening with the registration of the entrants in Florida. The domestic assistance program only began in January. I don't think that it will hit the levels which Florida has projected for 1981, but we will see this when the actual cost reports are submitted.

SOCIAL SERVICES DECREASE

Senator CHILES. Well, for social services, you show a decline of $16.5 million or 52 percent. If we use the Florida estimates of a 10.2-percent decline, then we've got another $13.3 million short. In the current fiscal year you requested a contingency fund of $20 million to cover the uncertainty in caseload estimates.

Mr. FORBUSH. Yes.

Senator CHILES. Since we've got a $54 million difference between Florida's estimates and yours, don't you think we ought to have a little contingency estimate this year?

Mr. FORBUSH. In 1982?

Senator CHILES. Yes, sir.

Mr. FORBUSH. I can only say there just wasn't room for it in the budget.

PUBLIC ASSISTANCE DEPENDENCY ASSUMPTIONS

Senator CHILES. Well, it looks like the 1982 budget assumes that only 25 percent of the alien 1981 entrants are going to be dependent or on public assistance.

Mr. FORBUSH. That is the assumption.

Senator CHILES. Given the kind of mix that Castro sent out, you know—we didn't get the middle class and the professional people this time. We got a lot of the people out of the jails and the people out of the institutions.

Mr. FORBUSH. I think the percentage that is in that category is relatively small. Most of the Cubans were people who joined families already here in the United States. When we look at the 125,000 Cubans you're not going to see a large percentage of people who are criminals or who spent a long time in jail for serious crimes as opposed to political differences.

Senator CHILES. You wouldn't want to bet a dinner, though, that 25 percent is right, would you?

Mr. FORBUSH. Perhaps a lunch, but not a dinner.

Senator CHILES. Well, let me ask you this. Assume that the State is right and you're wrong, or closer to being right than you all are. What happens?

Mr. FORBUSH. Well, we are faced with a very difficult choice. We either have to come up with a supplemental to maintain the policy of 100-percent reimbursement or we have to revise the policy of 100-percent reimbursement—a very uncomfortable situation.

Senator CHILES. Well, that second choice that you made is the one that makes the hackles on my hair stand up.

Mr. FORBUSH. Yes.

FEDERAL RESPONSIBILITY FOR CUBAN/HAITIAN ARRIVALS

Senator CHILES. The idea that we would reverse that policy, because it was not the State of Florida—it was not south Florida that said, "Come on in. We've got open arms here." And it was not their policy or absence of policy that brought these people here.

Mr. FORBUSH. Well, as I say, in the current budgetary atmosphere, it would be impossible to add funds right now. I think that somewhere down the line, if we had good, solid data and evidence, then that might be possible.

Senator CHILES. Has not the Reagan administration said that they recognize that this is a Federal problem?

Mr. FORBUSH. Yes, sir; they have.

Senator CHILES. A Federal responsibility?

Mr. FORBUSH. Yes.

Senator CHILES. Well, then, the question is whether they are going to match that rhetoric with the dollars that are needed.

Mr. FORBUSH. That's correct.

IMPACT ON LOCAL SCHOOL DISTRICTS

Senator CHILES. Many local districts are complaining that the Indochinese refugees and Cuban or Haitian refugees represent a federally imposed burden on the local school system and the Federal Government should share more of the cost of the education of these children. How do you respond to that criticism?

Mr. FORBUSH. Well, the budget request does include funds for education. We have asked the Department of Education to administer that on our behalf. I would interpret that question to mean that the amounts per child that are provided in the budget are inadequate, but I'm not quite sure what the——

Senator CHILES. Well, I understand these costs are based on just what it costs to teach a child English. What funds are available to pay the other costs to a district which receives a massive flow? Dade County got 14,000 extra students. That will take 17 additional schools. So the entire county had to go on double sessions. Surely you wouldn't say that that massive burden is covered by per student cost to teach English, is it?

Mr. FORBUSH. I'm not sure that's per student cost to teach English. I think we have about $300 per child in the budget request and I think that one of the assumptions in the budget as well is that this is to cover incremental and extraordinary costs not basic, routine costs.

Senator CHILES. Well, do you think it's a routine cost if you've got to set up 17 new schools?

Mr. FORBUSH. I don't understand that.

Senator CHILES. I'm saying that's the population that you put in, that you would be covering that with 17 schools.

Mr. FORBUSH. Well, some of these schools perhaps had been sited for closing and did not close.

Senator CHILES. The schools weren't there. They just had to go to double sessions.

Mr. FORBUSH. It's the equivalent to 17 schools?

Senator CHILES. That's right.

Mr. FORBUSH. I see. I'm sorry. I can't add any more to that.

ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME

Senator CHILES. One of the major problems that we have had with the Cuban program is the large amount of medical and social service costs generated by the SSI eligible population. In the old program we found that while 25 percent of Dade County's population is Cuban, two-thirds of the SSI recipients of the county are Cuban. It looks like we're going to have the same problem with the new group. That was because, again, Castro had sent out the cripple and the lame so there was a much higher proportion of SSI recipients to the percent of the population that they actually represented.

Florida estimates that 10,000 or almost 6 percent of the 169,000 entrants are SSI eligible. That's almost 4 times as much as the 1.6 percent of the SSI eligibility rate for the United States as a whole.

What do you estimate is the cost of continuing the 100-percent funding for SSI-related costs under the old Cuban program?

Mr. FORBUSH. Roger, do you have that?

Mr. WINTER. You're correct that that proportion of the program was the largest piece of the program, but I have to look up that impact figure for you.

Senator CHILES. If you will get that and submit it to us for the record, and I'd like to know whether you concur with Florida's estimates of SSI eligible for the new entrants and whether that same high SSI relates to Indochinese refugees as well.

[The information follows:]

SSI-RELATED COSTS FOR REFUGEES AND ENTRANTS

Section 313(c) of the Refugee Act of 1980—Public Law 96-212—provides for a phasing out of the old Cuban refugee program previously authorized by the Migration and Refugee Assistance Act of 1962. In fiscal year 1982, ORR is authorized to reimburse 45 percent of the non-Federal costs of assistance to Cuban refugees who entered the country prior to October 1, 1978. However, section 313(c)(2) provides for 100-percent reimbursement for non-Federal costs for Cuban refugees who are SSI recipients. These non-Federal costs of SSI recipients are primarily medical costs.

The fiscal year 1981 budget includes $13.5 million to pay for the medicaid costs of these Cuban SSI recipients. The fiscal year 1982 budget request contains $11.5 million for this purpose.

Medical costs for all other refugee SSI recipients—including Cubans that enter after September 30, 1978—are covered under the provisions of the Refugee Act of 1980, including the 36-month limitation which will become effective April 1, 1981. The medical costs for entrant SSI recipients are covered under the Cuban/Haitian entrants program. Both programs provide for 100-percent reimbursement of all costs incurred during the eligible 36-month period.

REFUGEE AND ENTRANT SSI RECIPIENTS

Florida has indicated that about 10,000, or almost 6 percent of the entrant population in the country are SSI eligible. The national coverage for SSI eligibles is 1.6 percent.

We believe the Florida estimate is on the high side. The HHS Cuban/Haitian Task Force has compiled statistics on the age compositions of the entrants resettled from the various resettlement camps. Their records show less than 1 percent of Haitian entrants—46 of 24,743—are age 65 or older, and that only 3.7 percent of Cuban entrants—4,617 of 124,779—are 65 or older. These people are eligible for SSI on account of age. It is difficult, if not impossible, to estimate how many entrants would qualify for SSI on the factors of disability or blindness. However, we do not believe it would be as high as 2.5 percent—in order to bring the total SSI eligible rate to the level indicated by Florida.

There are more definitive data concerning Southeast Asian refugees who are SSI recipients. In September 1980, the refugee population in this country was 415,239. The Social Security Administration records have 7,848 refugee SSI recipients. The SSI recipients represent about 2 percent of the total refugee population in the country at the time, which compares very favorably with the national average.

MEDICAL ASSISTANCE TO ENTRANTS

Senator CHILES. We have had some trouble arranging for payments to private voluntary hospitals in Florida who served many of the entrants. Would you tell us what arrangements have been made so that this can proceed? It's my understanding that since the States ran the medicaid program we were going to give them the prime responsibility for channeling the funds.

Mr. WINTER. You're accurate. There has been some difficulty in resolving that problem. It did relate, at least in part, to interpretation of the appropriation language. We have worked out an agreement with the State of Florida this week which provides a mechanism for processing private hospital provider claims for services provided to Cubans and Haitians after April 21. So we believe we now have at least a mechanism in place that will permit us to honor those claims.

Frankly, sir, we want to. It was just a matter of sorting through both the legalities and the procedures.

Senator CHILES. Would you explain to me, then, who is going to certify that and what the role will be of the office of the State now?

Mr. WINTER. What we have worked out with the State is an arrangement whereby the local provider agency will certify the claims. They will process those claims in one of two ways. For services to individuals still in INS custody, claims will be directed to the Public Health Service; if the individual was not in the INS detention, claims for service will be forwarded to the State of Florida. The State of Florida is assisting with the review of those claims under guidelines that we have agreed upon. After those claims are reviewed and agreed to, we will issue a grant award to the State of Florida that will hold the State of Florida harmless for the actual validity of the claim. This is reasonable since the local provider has already certified to that validity. As part of the local provider's certification we will include a statement that they will reimburse the Government if it's found later, upon audit, those claims are not allowable.

Senator CHILES. That sounds reasonable. I'd like to check it with the local people and see that the certification system is feasible.

At one point a while back it sounded like we were in a catch 22 where there was no way that the hospitals could get reimbursed, yet they had provided the services, and it was going to be an expense to the State.

Mr. WINTER. I believe we are in very clear agreement with you. The hospital providers responded very helpfully at very difficult times. We actually do want to make those claims up to them, but——

Senator CHILES. You had to find a way to get around it?

Mr. WINTER. Yes, sir.

MENTAL HEALTH SERVICES

Senator CHILES. There's a concern that refugees have great difficulty adjusting to life in this country and as a result of the often traumatic ways they have had to leave their homeland and the different culture, such mental health problems can impede the refugee's ability to function productively in his or her surroundings.

What kind of coordination is there between the Office of Refugee Resettlement and the National Institute of Mental Health? Would you outline that for us?

Mr. WINTER. Perhaps I can at least start. There are some differences between whether you're talking about the Cuban and Haitian entrant program or whether you're talking about the regular refugee program.

Under the refugee program, mental health services are eligible services to be provided by State and local providers. We coordinate that activity in a number of ways with the Office of Refugee Health Affairs—ORHA—which is within the U.S. Public Health Service. As a matter of fact, ORHA has an outstanding facility within our central office to help facilitate that kind of coordination.

Mr. FORBUSH. When we're dealing with Cuban and Haitian entrants, the National Institute of Mental Health and the Public Health Service supervise the care for these patients both while they remain in our custody at a camp and if needed after Federal custody thereafter. Would you like to add to that, Larry?

Dr. SILVER. The National Institute of Mental Health works with the Public Health Service in doing initial screening for mental health problems. We set up a mental health service in resettlement camps and we help with the screening when people left the camp. We are currently providing services in Fort Chaffee and at the facility in Washington, D.C. At this time we are involved in finding a long-range place for those who need further care. Also, in the summer, with the additional Senate appropriation, we were able to fund some of the community mental health centers around the country that were heavily impacted. In the Dade County area we provided supplemental funds to Miami Mental Health, Northwest Dade, Jackson Memorial Hospital, and, because of the number of patients, we moved into Fort Lauderdale. We opened a new mental health hospital and gave them supplemental funds to provide for the additional overload.

CUBAN RESETTLEMENT

Senator CHILES. There's been a fair amount written in the press about the plight of the Cubans still interned at Fort Chaffee in Arkansas. Despite assurances that sponsors are going to be found, the pace of clearing the camp appears to be slow. How many Cubans remain in Fort Chaffee awaiting sponsors?

Mr. FORBUSH. Just under 4,000.

Senator CHILES. What are the problems that are making placement of these remaining Cubans so difficult?

Mr. FORBUSH. Well, to some extent the problem——

Senator CHILES. In other words, what I'm really asking for is when can we expect them in Miami?

Mr. FORBUSH. Our policy on closing down Fort Chaffee is resettlement is done outside of Florida. Florida may be their secondary resettlement. We don't resettle people from Fort Chaffee into Florida.

Senator CHILES. Do you have any figures on what the secondary migration actually is?

Mr. FORBUSH. I'm afraid I do not.

Senator CHILES. Don't you think that's something we ought to be following?

Mr. FORBUSH. I think it would be useful to get that together. It's very difficult to provide data on secondary migration. We are resettling approximately between 900 and 1,000 people a month and of the 4,000 that are at Fort Chaffee now, about 1,000 will be required to remain in Federal custody one way or another. Dr. Silver was talking about the mental health placements—those will be a little different than normal sponsorships. But we have worked with the voluntary agencies and solicited proposals from other organizations who have not previously been involved in resettlement to try to work out a sponsorship that is really tailored to the needs of this group so we don't have a high rate of sponsorship breakdown. I think the length of time it has taken is really a function of that kind of care, care that probably would have been useless for us to exert much earlier in the program. We have to deal with problem cases out of Fort Chaffee in a way that responds to their needs.

REGULATIONS FOR REFUGEE ASSISTANCE

Senator CHILES. Your statement notes that you're developing a new comprehensive regulation for refugee assistance that would cover all categories of refugees and entrants. What major program changes are you planning in each of the areas of cash, medical, or child welfare and social services?

Mr. FORBUSH. The changes that are being proposed are in the budget document. The major change deals with the level and availability of cash assistance. At present the program provides benefits equal to AFDC for single persons and childless couples who are not otherwise eligible for AFDC under the regular program. Under the new proposal, this group would receive the general assistance rate if the State had that program or the AFDC rate for 18 months and then half the AFDC rate for the second 18 months.

We are also proposing to discontinue the income additions for those who are on the general assistance equivalent benefits.

Senator CHILES. Are you going to be restricting social services?

Mr. FORBUSH. No; there's no plan to restrict the categories of services. We want to try to focus the program changes on those that are most closely related to adjustment to society and to employment.

Senator CHILES. When will the draft regulations be available for comment?

Mr. FORBUSH. They should be published in the Federal Register within the next month. I have the draft for my review right now.

SUBMITTED QUESTIONS

Senator CHILES. I have some other questions that I will submit to you for the record. If I sound frustrated by the questions I have asked, it's because I am and the people in Florida very much are. I do want to say to both of you, Mr. Forbush and Mr. Winter, we appreciate the individual efforts that you have made in trying to help us with this program. Thank you for your appearance.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

Contingency Reserve

Question: Of the $20 million contingency reserve appropriated in FY '81 for emergency expenses related to Cuban/Haitian Domestic Assistance, how much money is left?

Answer: As of the end of the second quarter of FY 1981, none of the $20 million contingency reserve funds had been spent.

Question: What plans, if any, do you have for the balance of these funds?

Answer: We are now reviewing the States' estimates for cash and medical assistance and related administrative costs and their actual expenditures to date. As yet, no determination has been made of whether the reserve funds will be needed.

Use of Consultants

Question: Why does the Office of Refugee Resettlement (ORR) need consultant services? What functions are there that consultants can perform which the ORR cannot?

Answer: ORR requires consultant services to complement its evaluation and data collection activities. The Policy and Analysis Division of ORR is charged with developing evaluation criteria and designing evaluations in order to determine the degree of accomplishment of the refugee programs. The Division collects data on the needs of the refugee population and identifies data needs and sources. This Division is quite small and does not have adequate in-house resources (staff, travel funds, etc.) to do the field work requisite for the typesof studies that must be done prior to its evaluation and data analysis.

Question: Are all your contracts awarded on a competitive basis?

Answer: All ORR consultant contracts are awarded on a competitive basis.

Question: Provide a list for the committee of all those who have received consultant contracts under the Refugee Program in FY '80 and FY '81, the amount of the contract and the purpose for which it was made.

Answer: Contracts under the Refugee Program in FY 1980 and to date in FY 1981 include:

FY 1980

1. New Transcentury Foundation ($4,659)

   o Factual analysis of data on extent to which Southeast Asian refugees have become self-supporting, wage and income trends, differences in such trends related to refugees' dates of arrival in the U.S., and labor force participation and employment rates.

   o Socioeconomic and demographic impact on U.S. of arrival of Southeast Asian refugees:

- Impact on U.S. labor force and employment market, and expected displacement of American workers;
- Types of jobs expected to be filled by refugees; and
- Degrees and rapidity with which refugees participate in the labor force and obtain employment.

2. Wade Ragus	($726)

Provision of one-day seminar to familiarize ORR staff with refugee housing issues and options.

3. Study of Hmong, Refugee Resettlement Strategies	($8,000)

Field research and analysis of adaptation of Lao Hmong refugees in San Diego focussing on their adjustment as an ethnic community on the relation of Hmong to host community on strategies and results of resettlement, on effects of change and continuity on individual and family adjustment.

FY 1981

1. Robert Bach	($855)

Provision of technical assistance to ORR for planning of data analysis. Contractor provided guidance on use of ADP software, determination of appropriate statistical analyses, interpretation of results, relevance of these interpretations to general refugee resettlement.

Hostility Toward Refugees

Question: There is concern that the massive influx of refugees has already begun to create an environment where a "backlash" or strong sense of hostility towards these newcomers will result in violence. What steps is the Federal Government taking to minimize the chances of this kind of backlash developing?

Answer: The Office of Refugee Resettlement attempts to keep abreast of all refugee-related events across the country and works with a myriad of organizations both nationally and locally to help stem off negative developments regarding refugees in the U.S. ORR has established offices in each HHS Region to develop and maintain contact with States and localities in that Region. These Regional Offices are able to assist in the mediation of problemmatic situations and to call on other arms of the Federal government, for example, the Community Relations Service in the Department of Justice, to assist them. ORR also has a public affairs officer in its central office to call attention to possible developments and provide information to both central office and the Regions. Finally, within the Operations Division of ORR, the Regional Affairs staff serve as a formal liaison between the Regional Directors and ORR top management in Washington, through their expertise regarding the field and their proximity to central office decision-making. ORR notes that the phenomena frequently referred to as "backlash" in communities upon investigation often turns out to relate to a more generalized frustration with immigration-related problems (e.g. illegal aliens) as opposed to specific refugee-related frustrations.

Question: What specific instances of violence or antagonism has the Office of Refugee Resettlement dealt with, and what success has it had?

Answer: Currently, there is a great deal of tension along the Gulf Coast ofTexas between refugee and local Texas Fishermen. The problems stem from inadequate understanding of fishing rules of refugee fishermen and misperceptions by the local fishermen of the public assistance received by refugees. The language and cultural barriers create even greater distance between the two sides. ORR's Regional Office in Texas has provided extensive support to the Governor's Office in Texas, assisting in mediation, providing some interpreting services, calling on other individuals and agencies to provide assistance, and providing clarification of Federal policy where needed.

Difference In Refugee Needs

Question: It is obvious that the needs of the differing kinds of refugees coming to this country vary widely. One presumes that Vietnamese refugees who have lived in a large city such as Saigon, have fewer troubles than pre-literate Hmong tribesmen from the mountains of Laos in adjusting to life in this country. What special provisions does the refugee program make to help those refugees with a very different cultural background, such as Hmong tribesmen, get used to American society?

Answer: The Office of Refugee Resettlement (ORR) is aware of the special needs of certain of the refugee populations who arrive in the U.S. ORR has taken advantage of the flexibility in the current law and instituted several steps to provide for these special needs.

First, ORR and the Indochinese Refugee Assistance Program (IRAP) that preceded ORR, made provision for extensive social services programs to be available to refugees in each State, beyond those services permissible under the State's Title XX program. An action transmittal issued August 24, 1979, (SSA-AT-79-33) expanded allowable social services under IRAP to include services such as outreach, assessment, English as a Second Language (ESL), skills recertification, social adjustment services, and others that various refugee subgroups might need. Moreover, this action transmittal permitted States to establish purchase-of-service contracts with counties and voluntary agencies, thereby increasing the likelihood that a variety of services would be provided to the many different refugee groups.

A second step taken by ORR to provide for special needs of certain refugee groups is the creation of certain special projects. ORR has funded projects in the United States which provide English language training, cross-cultural orientation, and employment related information. These projects also provide wide dissemination of this information, to refugees and their sponsors, voluntary agencies, local service providers, and mutual assistance associations.

Thirdly, ORR has maintained a flexible position in programming where unique needs and circumstances seem to encourage unique approaches. The continuation of the matching grant program, now used primarily for Soviet Jews, is a primary example. However, ORR is exploring other such efforts, particularly in attempts to reduce dependency on public assistance, where such efforts appear cost effective and to yield improved resettlement of refugees.

Finally, ORR strongly supports the development of mutual assistance "self-help" associations (MAA's) in the various refugee communities. There has been a tradition in the U.S. throughout its history of more established immigrants helping newly arrived compatriots. ORR views the proliferation of MAA's in the last few years as a welcome sign that refugees are committed to helping each other, which will enable even the most culturally disparate groups to adjust to the U.S. ORR has provided grant money to some MAA's this year and remains committed to supporting the work of MAA's in the future.

Question: In your opinion, should the Federal Government by statute or by regulation, create different standards for benefit eligibility for refugees with distinct problems and backgrounds? What would the advantages and disadvantages of such an approach be?

Answer: ORR does not believe that the Federal Government should create different standards for benefit eligibility within the public assistance portion of the program for different groups of refugees. As stated above, the social services programs are already geared towards the variety of needs specific to refugees. However, likewise, initiatives designed to provide for alternatives to cash assistance can and should take special circumstances into account. The cash and medical assistance programs are transitional in intent, providing otherwise destitute refugees with basic assistance to enable them to begin to adjust to life in the U.S. Variation beyond the variation already existing between States appears to raise substantial questions of equity and administrative complexity.

Assistance to Entrants

Question: How many of the roughly 150,000 Cubans and Haitians who have entered this country in the past year are presently receiving cash or medical assistance payments?

Answer: Funding for ongoing cash and medical assistance for recently-arrived Cubans and Haitians was authorized on October 10, 1981. Most States have begun programs for assistance for Cuban and Haitian Entrants only recently. Therefore, the States are just beginning to process applications and place eligible Entrants on public assistance. Meaningful data is not currently available as to the numbers of Entrants on cash or medical assistance. For example, the State of Florida which has the overwhelming percentage of Cubans and Haitians only began to receive applications for cash assistance on January 14, 1981. From the limited data available, however, it is clear that Haitians are applying and receiving cash assistance in much lower numbers than gross population figures would cause ORR to anticipate.

Question: How many Cuban/Haitian Entrants do you expect will be receiving Federally reimbursed social services in FY '81 and FY '82?

Answer: Preliminary indications ORR has received from the States are that almost 100 percent of adult Entrants will need social services of some sort. ORR has awarded $9.6 million in grants for social services to date. The exact number of Entrants who will actually receive social services in either FY 1981 or FY 1982 is not yet available,since some States have just set up a social services program while others have not yet.

ORR data at present shows 4,000 Entrants will receive social services in FY 1981. This may understate the number of Entrants who will receive social services this year due to situations in the largest Entrant population States. For example, California's State legislature has not yet voted to accept federal funding for the program so it is not yet operative. New York and New Jersey have sent out requests for proposals (RFP's) for social services contracts, and Florida is still preparing its RFP's, so the programs are not operational in those States either. Once these four States get social services programs for Entrants going, we will be better able to estimate thenumbers of Entrants receiving these services.

Question: How many taking English-as-a-Second Language (ESL) courses?

Answer: For all the reasons stated above, ORR does not yet have data on the number of Entrants taking ESL courses.

Secondary Migration

Question: Our experience from the last Cuban influx was that we get a tremendous "secondare migration," that is, refugees who are originally resettled in one place, but who move after a few months to Florida to become part of the larger immigrant community. I am told California is now having the same problem with Indochinese refugees. What data does the Office of Refugee Resettlement have on the problem of secondard migration?

Answer: The data that ORR has on secondary migration of southeast Asian refugees is based primarily on the Alien Address Report done by the Immigration and Naturalization Service. This report establishes the locations of Southeast Asian refugees around the U.S. each year in January, by the refugees' submission of post cards to the INS. (Response rate has averaged 85%.) ORR uses this report to estimate net secondary migration of these refugees. In the past few years, California can be shown by this method to have gained (net) 8,000-9,000 yearly, Texas and Washington about 1,000 each, some other states a few hundred. The majority of States lose rather than gain.

For 118,000 Cubans who arrived during 1980, about 75 percent of them settled in Florida. Thus the potential for secondary migration is only 29,500 Cubans. It is very difficult to identify those Cubans who have migrated to Florida from their original place of resettlement (or other refugees, other than Southeast Asians, who have similarlymigrated) because the Federal government has not begun to track them. ORR's Miami Office has identified only 179 persons who have migrated to Miami.

Question: What steps has ORR taken to help states which have this particular problem?

Answer: Nearly all of ORR's funding to States is based on State refugee population. ORR has used States' estimates of needs to provide cash and medical assistance and related administrative funds and has, to date, been able to meet actual costs. ORR also attempts to take secondary migration into account in allocating its social service funds to States. In the past there have been instances of disagreement between ORR projections and State estimates of secondary migration with respect to social service allocation procedures.

Question: California's Office of Refugee Services has suggested that many refugees arrive in California after they have already been in this country some 8 to 18 months. These refugees then have only 18 months of eligibility remaining for Federally-funded training education, and especially cash and medical assistance. California officials have suggested that a refugee's three-year eligibility period start when a refugee first applies for government assistance, not from date of entry. What might such a change in policy cost the Federal government?

Answer: Neither ORR nor the States keep data on the time period between a refugee's arrival in the U.S. and the date of the refugee's application for public assistance. This time period is critical in determining the cost of the policy change suggested by California's officials. If we had this type of data, we could calculate the cost as the number of months between arrival and application multiplied by the estimated unit costs of serving the refugees (cash and medical assistance and related administration). For example, if a refugee arrived in the U.S. on January 1 and does not apply for public assistance until May 1, he or she has lost four months of his or her 36 months of eligibility for Federal refugee assistance. The California suggestion would thus cost the Federal government four extra months of support to that refugee. Obviously, the longer between the refugee's arrival and application the greater the cost to the Federal government under this proposal.

Question: Could such a change in setting eligibility standards be accomplished administratively or does it require a change in legislation?

Answer: Any change to permit federal funding of assistance to refugees after they have been in the U.S. for 36 months would have to be made statutorily.

Question: What would be the advantages and disadvantages of such a change?

Answer: The disadvantages of such a change are twofold. First, a higher appropriation would be required to meet the costs of the change. Second, an extensive Federal/State reporting network would be needed to enable both the Federal and State governments to know when the date of application for upblic assistance was for each refugee. The States perceive an advantage in such a change because they will be able to receive greater funding for some refugees.

Education

Question: In FY '80, $7.7 million was appropriated to help meet increased educational costs due to the influx of Cuban and Haitian children. Has this money been distributed?

Answer: This money will not be distributed until the end of March.

Question: Which school districts received aid, and how much aid per child was paid?

Answer: No data on who received aid and the amount is available yet. The amount of aid per child depends upon the length of time that the child has been in the U.S. Those children who have been in this country the least amount of time are weighted the most heavily to receive aid.

Question: How much extra does it cost a school district according to your best estimates, to provide a good education to a Cuban or Haitian entrant?

Answer: This is a difficult estimate to make. Educational costs vary between States and between school districts within a State. We have also not yet been able to do an assessment of educational needs of the Entrant population.

Question: How are funds for refugee education distributed?

Answer: ORR, through an interagency agreement with the Department of Education, provides funding to local school districts to help them meet special needs -- mostly English language training -- of refugee children. A total of $23 million was appropriated in FY 1980 under the Refugee Act in support of this education assistance for refugee children in elementary and secondary schools. Allocation of these funds is by formula grants, for use during the 1980-1981 school year.

Question: How many school districts currently receive funding for refugee education? How many children?

Answer: We will not have data from the Department of Education on these figures until the end of March because the awards to the State Educational Agencies will not be made until then.

Question: For how long does the Federal government provide assistance for the increased cost of educating refugee children? Should there be a time limit on such assistance?

Answer: The Federal government provides this funding through FY 1982. The time-limited nature of this assistance is consistent with the transitional intent of these programs. The time limitation is also consistent with Federal educational programs for other limited or non-English speaking portions of the population.

Question: Of the Indochinese refugees who have entered the United States since 1979, what percent are literate in their native language?

Answer: We can only roughly estimate the number of Southeast Asian refugees who are literate in their own language. About half of the Southeast Asian refugees who have come to the U.S. since mid-1979 are children who have not yet learned to read and write their own language. The primary other non-literate group is the Hmong from Laos. Using these two facts we estimate that, of the 230,287 Southeast Asian refugees who arrived in the U.S. between July 1979 and December 1980, about 80,000 are not literate in their native language.

Question: How many speak English?

Answer: Based on a survey of Southeast Asian refugee arrivals in calendar year 1979, 6.5% have English-speaking ability of "good" or better, 27.9% have "average" ability, and 65.6% speak little or no English.

Question: Of refugees who have arrived since 1979, how many at this time have jobs?

Answer: Again, based on a survey of Southeast Asian refugee arrivals in calendar year 1979, 48.6% of those aged 16 or older have jobs. The reason that this percentage is somewhat low is because many of the refugees are in the age range 16-22 and are in school. Of those who are in the labor force, the employment rate is 83% (i.e., 17% unemployment rate).

Question: As of April 1st of this year, how many Indochinese refugees currently receiving Federal assistance will cease receiving aid, because they have been in this country more than 36 months?

Answer: We estimate that as of April 1, 1981 between 30,000 and 55,000 Southeast Asian refugees will no longer be eligible for Federal funding because they have been in the country for over 36 months.

Question: Provide for the Committee a list of the number of refugees, by state, who have entered the United States since January 1, 1979.

Answer: Attached is a list of refugees, by State, who have entered the U.S. since January 1, 1979.

Indochinese Refugees Entries into U.S. by State of Initial Resettlement

STATE	Year 1979	Year 1980
Alabama	812	818
Alaska	65	135
Arizona	930	1,154
Arkansas	686	969
California	33,442	47,270
Colorado	2,189	2,482
Connecticut	1,201	1,598
Delaware	26	76
District of Columbia	2,696	3,004
Florida	2,455	2,702
Georgia	1,339	2,407
Hawaii	2,268	1,882
Idaho	189	346
Illinois	4,850	6,426
Indiana	1,178	1,365
Iowa	1,951	2,460
Kansas	1,235	1,698
Kentucky	607	683
Louisiana	1,586	2,196
Maine	222	245
Maryland	748	1,227
Massachusetts	1,412	3,684
Michigan	2,144	2,923
Minnesota	3,971	6,707
Mississippi	324	384
Missouri	1,191	1,530
Montana	379	340
Nebraska	650	672
Nevada	601	572
New Hampshire	84	118
New Jersey	712	1,568
New Mexico	669	1,204
New York	4,602	5,436
North Carolina	1,201	1,582
North Dakota	336	249
Ohio	1,707	2,332
Oklahoma	1,728	2,060
Oregon	3,270	5,759
Pennsylvania	4,897	5,843
Rhode Island	692	1,017
South Carolina	341	502
South Dakota	314	334
Tennessee	1,699	1,553
Texas	8,360	11,439
Utah	1,775	3,213
Vermont	32	181
Virginia	1,751	3,098
Washington	4,743	7,462
West Virginia	134	216
Wisconsin	1,614	2,038
Wyoming	56	121
American Samoa	---	---
Guam	62	57
Puerto Rico		
TOTAL	112,126	155,337

State Participation

Senator Hatfield: It is my understanding that the States have virtually no voice in the refugee resettlement process, in spite of the fact that they are responsible for developing an organized social service delivery system for these new residents. Apparently, the U.S. State Department and voluntary agencies have exclusive control over the number and timing of refugees entering the State. Please comment. Do you see room for increased participation on the part of the States?

Answer: It is the general position of this Department that the domestic impact of refugee admissions has not always been fully considered in previous discussions and consultations on refugee flows. In recognition of this, the U.S. Coordinator for Refugee Affairs, in coordination with the Office of Refugee Resettlement, has developed an extensive consultation process to discuss the resettlement of refugees in the United States with all of the participants in the resettlement process. States, local governments, other local provider agencies, and refugee mutual assistance associations, as well as the national voluntary agencies have been and will continue to be part of these consultations. In the past year, the Coordinator's Office and ORR have co-chaired five Regional conferences, in Seattle, Los Angeles, Philadelphia, Chicago, and Dallas, to discuss the status of refugee resettlement in those particular areas. The Coordinator plans many future discussions and conferences with the relevant actors in order to develop an effective and appropriate resettlement process that meets both the needs of the refugees themselves and the capabilities of the service delivery agencies.

In addition, ORR has recently funded a special demonstration effort with regard to resettlement of Cambodian refugees arriving during FY 1981 which is designed to draw a meaningful number of these refugees away from already impacted areas. Under this project cluster resettlement will be targeted the less impacted areas after consultation with state and local officials and arranging for needed services. The newness of this project, which is being carried out in coordination with the national voluntary agencies, precludes drawing conclusions at this time regarding its success or failure.

Social Services

Senator Hatfield: Oregon, along with other Pacific Coast states, is fast reaching a saturation point in the number of Southeast Asian refugees entering each month. In spite of the skyrocketing numbers, drastic funding cuts have been proposed by the Administration for the Office of Refugee Resettlement. I raise the following questions in order to help evaluate the appropriateness and effectiveness of certain policies proposed for the ORR. How is the funding formula derived for level of assistance to states under this program?

Answer: Funds provided to States in FY 1981 for cash and medical assistance and related administration have been based on States' estimated needs for these activities and actual reimbursement will be provided for 100% of a states costs for these activities to the extent of available appropriations.

Funds provided to States for social services in FY 1981 are based on a distribution formula that provides each State with no less than 75 percent of its FY 1980 social services allocation and another portion of the remaining funds based on the State's proportion of newly arrived refugees (i.e., those Southeast Asian and Cuban refugees resettled between October, 1979 and July, 1980).

Senator Hatfield: Does the formula take into account the relative numbers of refugees over time which the State must absorb?

Answer: Funding for cash and medical assistance and related administration is 100% reimbursed to states to the extent of available appropriations, thus fully accounting for a state's actual costs. The social services funding for FY 1981, which has been considered a transition year for the refugee social services programs, is based on a guarantee to states of their receiving no less than 75% of the FY 1980 allocation plus an additional factor based on new arrivals. Additional funds were provided to some states, including Oregon, based on ORR's evaluation of state need.

Senator Hatfield: Is success of existing programs a factor, so that states are encouraged to develop innovative and efficient programs?

Answer: "Success" of existing programs is not currently a factor in any of the funding allocation formulae. However, given the limited amount of social services funding currently available, States are quite careful to examine the quality of the social services contracts that they let and to set priorities for the services they wish to purchase. The law's current limitation for federal refugee reimbursement for cash and medical assistance to the first 36 months of a refugee's residence in the United States creates a further incentive for states to utilize social service funds in a manner that best forestalls refugee dependency.

Senator Hatfield: With the use of federal refugee funds, combined with state-provided social services, Oregon has been very effective in bringing the refugees up to a level of self-sufficiency and finding them a job, thus avoiding public assistance. However, with the steadily increasing numbers of refugees who have greater re-settlement needs, it is impossible to keep up. With the present funding formula, those states with a growing refugee population are penalized, because the allocation is based on last year's social service allocation. Have alternatives to this formula factor been discussed?

Answer: Alternatives to the social services allocation formula are currently being considered for implementation in FY 1982. The formula used for FY 1981 was a transitional formula, which attempted to avoid undue disruption of existing programs while still allowing some change for new population additions.

Senator Hatfield: Those refugees who arrived in the United States in 1975 were educated and familiar with some aspects of Western culture. Thus, many readily adapted to America; others are still in transition. Of the more recent refugee arrivals, however, most have had no opportunity for formal education and are unsophisticated about western life. Do the programs and policies of ORR reflect these differing needs?

Answer: As mentioned earlier, in response to Senator Chiles' question, ORR has attempted to build a great deal of flexibility into its programs to enable the different refugee sub-populations to be treated individually. ORR has mandated that social services and service providers be defined more broadly for refugees, that mutual assistance associations be encouraged to help their fellow refugees adjust, and that certain national projects provide cross-cultural, multi-lingual orientation materials for all of the participants in the resettlement area to benefit from.

Senator Hatfield: Is the educational/cultural status of refugee groups considered in the allocation of funds?

Answer: Our understanding of the pattern of resettlement of different refugee groups is that, although there are at times large differences between the various refugee groups, these differences are distributed across the States. Thus the social services funding formula, which allocates monies to the States, does not consider the educational or cultural status of individual refugee groups. If, in the future, there are distinct differences amongst the refugee populations in different parts of the U.S., these differences may become part of the allocation formula.

Senator Hatfield: State administrators of the program express concern over a possible separate ceiling being placed on the social service aspect of the ORR program. An arbitrary ceiling on the social service programs which allows refugees to get off the public assistance roles seems counter-productive. Would it not be more appropriate to allow state managers more flexibility in this area? Please comment.

Answer: The Refugee Act of 1980 authorizes a ceiling on social services and certain related activities. ORR's appropriation request separately identifies the amount for social services. Given these two facts, it is necessary that social service funds be allocated and accounted for separately. Since the amount available for social services is a result of the budget request and appropriations process, we do not consider it to be arbitrary.

Senator Hatfield: It has been claimed that many refugees are being brought into the state without adequate sponsorship. Please briefly outline the process for determining if such sponsorship is acutally present. What steps are you taking to assure that refugees in fact are adequately sponsored?

Answer: All refugees are provided adequate sponsorship before they are allowed to come to the United States. The Bureau of Refugee Programs (RP) in the Department of State has a process whereby assigned voluntary and state agencies agree to use their best efforts to assure successful resettlement of each assigned refugee into American life, leading towards economic self-sufficiency and minimizing dependency on state and local assistance. A new contractual agreement with the voluntary and state agencies list these specific required core services that are to be provided to the refugees. In addition, the agreement provides for certain optional services and for periodic programmatic and financial reports. The voluntary and state agencies are paid a per capita fee for each refugee resettled.

RP personnel regularly monitor the process of assigning sponsorship to appropriate voluntary and state agencies since this is a critical and sometimes time consuming element and the overall process of bringing the refugees to the United States and assuring that needed assistance and guidance is provided to refugees. RP personnel also are in continuous liaison with the voluntary agencies to help resolve any problems concerning sponsorship. In addition, the RP Bureau plans to award a contract this fiscal year for the evaluation of the resettlement process.

FORT ALLEN

Question:

Citizens of Puerto Rico have complained that it is unfair to send poor Cuban entrants to Fort Allen, since there is already so much poverty in their territory. What is the Administration's response to this criticism?

Answer:

On September 23, the Administration announced its decision to establish a temporary processing facility for new Cuban and Haitian entrants at Fort Allen, Puerto Rico. Although Fidel Castro closed Mariel Harbor later that month, the need for Fort Allen continued because of the flow of Haitians into south Florida and the inadequacy of the processing facilities there. Entrants processed through Fort Allen were to have been resettled in the continental United States, not in Puerto Rico; the only exception being immediate family reunifications. In addition, the preparation of Fort Allen has contributed to the Puerto Rican economy by providing jobs for over 700 local hires and contracts with Puerto Rican businesses.

Question:

Do you still plan to send new Cubans to Fort Allen?

Answer:

The U.S. Government has been enjoined by the U.S. District Court of the District of Puerto Rico from opening the facility, although an appeal has been filed. Pending final outcome of the case, Fort Allen is being maintained in a 30-day caretaker status.

Question:

How much money has been spent renovating and refitting Fort Allen to receive Cuban or Haitian entrants?

Answer:

Approximately $15 million have been spent on the Fort Allen facility. Over 80 per cent of these monies have been expended for salaries for local Puerto Rican hires and for various contracts within Puerto Rico.

MEDICAL SERVICES AND MENTAL HEALTH CARE

Question:

What kinds of emergency medical and mental health services have most Cubans and Haitians required?

Answer:

The spectrum of medical and mental health problems found among the Cubans and Haitians is similar to that found among American citizens, although the prevalence of some conditions is higher. Each Cuban and Haitian entrant is screened for illnesses such as dangerous contagious diseases, mental retardation, and certain mental illnesses. Preliminary medical care and mental health services have been provided in the camps, and back-up hospital care has been provided by Public Health Services facilities or purchased from clinics and hospitals in the vicinity.

Upon initial screening, 0.4% of the Cuban entrants and 0.1% of the Haitian entrants were found to have active or suspected active tuberculosis. Another 1.4% of the Cubans and 0.5% of the Haitians had inactive tuberculosis. Among the Cubans, 4.3% had positive reactions when tested for syphilis as compared to 19.2% among the Haitians. However, yaws, an endemic non-venereal disease in Haiti, contributed to the high prevalence of positive serologies among the Haitian entrants. Gonorrhea was detected in 0.9% of the Cuban entrants and 2.8% of the Haitians. Only nine entrants were diagnosed as having leprosy.

In the resettlement camps, primary medical care, including emergency services, were provided for a wide variety of respiratory, digestive, and dermatological conditions as well as from trauma. By November last year, approximately 11,000 entrants had been hospitalized. The most common reasons for hospitalization for the Cubans has been cardiac and other circulatory diseases, cancer, asthma, tuberculosis, and ingestion of foreign objects. For Haitians, dehydration and exposure from their long voyage to the United States, tuberculosis and skin infections have been principal reasons for this care.

Soon after the boatlift began, it became evident that there was a high prevalence of mental illness and mental retardation among Cuban arrivals such that many would require more than physical health care. Therefore, comprehensive mental health care was provided at each of the resettlement centers. Furthermore, arrivals requiring more extensive in-patient services were placed in psychiatric facilities in the surrounding communities and at PHS hospitals.

Among the Cuban arrivals, approximately 9,000 were referred to mental health care units within the camps for evaluation or treatment.

Many of the Cubans initially evaluated by the mental health teams were not mentally ill. Rather they were reacting to their new and stressful environment. Some showed behaviors that in this culture would suggest a psychotic process; but in retrospect it was felt to be a cultural expression of frustration and anger.

Through the end of last year, only two Haitians have been referred for psychiatric care.

Question:

Once these entrants find sponsors and leave the camps, are many of them likely to require medical or mental health care for extended periods of time?

Answer:

At the present time, there is no system for determining what medical or mental health care needs the entrants will develop once they are sponsored. However, it is clear that some entrants will require chronic medical or mental health care. All sponsors are encouraged to routinely take entrants for a follow-up medical check-up.

Physical ailments detected during the initial screening process or in the camps are treated. Since last November, an effort has been made to provide restorative dental care, eye care, and surgical correction of orthopedic problems or other elective surgical conditions. Entrants with active or inactive tuberculosis who are under treatment must have their treatment continued after they leave the camp, and the local health department in the area in which the entrant is resetttling is notified so that appropriate follow-up therapy can be assured.

Special placements are also being arranged for approximately 90 Cuban entrants from Fort Chaffee who are physically handicapped or who have chronic medical conditions (e.g., asthma, hypertension, diabetes) for which chronic care will be required.

Approximately 600-700 Cuban entrants will need continuing care for mental illness or mental retardation. These entrants will not be sponsored at this time but will have placements arranged for them in in-patient facilities or halfway houses.

The voluntary agencies have been interviewing the entrants prior to sponsorship. If there are any doubts regarding their mental health, a full psychiatric evaluation is performed.

Every effort is made to minimize the possibility of an entrant developing a psychiatric illness after sponsorship. Despite these precautions, some entrants with psychiatric illness have been released into the communities. This release occurred for one or more of the following reasons:

-- The first arrivals from the flotilla were screened by local health officers who had little time for mental health evaluations.

-- Some mentally ill entrants arrived with a two to three-week supply of their psychtropic medication. Once their medication was used up, they became symptomatic.

-- Psychotic illnesses are characterized by exacerbations and remissions. It is possible that some entrants were asymptomatic in the camps but became symptomatic under the stress of having to function, often with no job skills or knowledge of English, in an alien culture and country.

-- Some entrants with a chronic form of schizophrenia functioned adequately in the camp if there were no demands for interpersonal relationships or self-care. If these individuals remained quiet and non-communicative during the voluntary agency screening, they would not be recognized as having an illness. However, once resettled and under new stresses, their illness becomes evident.

Although every attempt is being made to resettle entrants while minimizing sponsor breakdowns for medical or mental health reasons, we are aware of 170 entrants whose sponsorship terminated and who have required hospitalization for mental health crises.

CUBAN CRIMINAL POPULATION

Question:

Almost 2,000 Cubans in last year's freedom flotilla were arrested as being potentially dangerous to American society. How many of the Cubans jailed upon arrival as criminals are still in jail?

Answer:

As of March 8, 1981, there were about 1,700 Cubans in Federal detention facilities whom INS believes to have engaged in serious criminal activities prior to their arrival in the U.S.

Question:

How many Cubans have had hearings and have been granted admission?

Answer:

Immigration judges had completed 1,456 exclusion hearings and had admitted 38 Cuban aliens to the United States as of March 8, 1981.

Question:

How many have been excluded?

Answer:

898 final orders of exclusion had been issued as of March 8, 1981.

Question:

What does the U.S. Government plan to do with those whom it feels should be excluded since Cuba refuses to take them back?

Answer:

INS' first priority with regard to exclusion proceedings has been to conduct hearings for those Cuban detainees with criminal backgrounds. According to INS, nearly all of the 898 Cubans who have been ordered excluded as of March 8 are being held in Atlanta, Federal Correctional Institution. To eliminate detention of persons where it is unnecessary and to ensure the safety of the American public, the Department of Justice is establishing a Release Review Panel to examine on a case-by-case basis Cubans being detained in Federal prisons. Within 12 months, the Panel will recommend (1) that the detainee be released from prison to an appropriate facility or (2) that he remain in prison pending further observation and review, after determining whether his release would present a threat to the community. Upon receiving the Panel's recommendation, INS retains final discretion to place a detainee whose release has been approved in an appropriate facility for release or directly parole him under sponsorship in the community.

Aliens ordered excluded, including those released from detention, may be legally expelled from the United States as such time as their departure can be effectuated. Release from detention does not remove the order of exclusion against the alien. INS continues to detain those Cubans ordered excluded and not cleared for release pending their repatriation to Cuba.

Question:

What safeguards are there to make sure that Cubans guilty of misdemeanors or of political opposition to Castro, are not held needlessly in U.S. prisons?

Answer:

The policy on detention of Cuban nationals is that those individuals found to be petty offenders or guilty of political crimes will not be detained. To implement this policy, all Cuban aliens with criminal backgrounds were interviewed by INS officers to determine whether they should be detained. The decision of the interviewing officer was then reviewed by a panel of at least three supervisory officers.

Almost all criminal detainees have now been consolidated at the U.S. Penitentiary in Atlanta, Georgia.

NEED FOR SPONSORS

Question:

How many sponsor/entrant relations have broken down in the past year, thereby requiring further Federal assistance in placement of these entrants?

Answer:

Although there are no exact figures on the rate of sponsorship breakdown, it is estimated that between 3% and 5% of the sponsor/entrant relationships have proved unsatisfactory and other arrangements have been made for the entrant. In the majority of cases, the entrant without a sponsor has found his or her own means of support, perhaps moving in with relatives or friends. In other cases, the entrant has applied for cash assistance and medical benefits through the Fascell/Stone Amendment to the Refugee Edcuation Assistance Act of 1980.

In some cases, entrants will ask local community action and Hispanic agencies for assistance. Often these projects provide basic resettlement services, including assistance in finding housing and employment, and they may be funded by the Federal, state, or local government.

Question:

What are the principal reasons for the breakdown of these relations?

Answer:

On the whole, the majority of breakdown cases have been family reunifications. Persons who had not seen each other in twenty years sometimes found that, for a variety of reasons, living together constituted an untenable arrangement. Reasons cited by the entrants for leaving their sponsors include the following: a lack of space in the sponsor's home, inability to find work in the area, a desire for independence, family problems, and personal conflicts.

Question:

What has the Task Force learned from its early experience that will help make future placements surer and more reliable?

Answer:

The first step in developing more successful sponsorships is through comprehensive and reliable screening of the entrants. The particular needs of the entrant must be identified before he is put into a resettlement situation which may eventually break down. In the early stages of the crisis, many entrants were released directly to relatives and friends with only minimal screening. Once the camp populations were consolidated at Fort Chaffee, however, the Federal Government has worked with the voluntary agencies to screen and assess more closely the physical and mental needs of the remaining entrants. As a result, the Task Force has found that some entrants are not ready for immediate placement into a community and require transitional living arrangements or longer-term institutional care.

Second, potential sponsors must also be screened in a thorough manner. While sponsorship is a moral, not legal, commitment, the sponsor must take seriously his responsibility and understand what is expected of him. If problems do arise, the sponsor should know precisely where he can go for assistance. When the capabilities of the sponsor are matched with the needs of the entrant, the entrant is more likely to integrate successfully into a community. Consequently, the Task Force is making every effort to provide sponsorhsip arrangements best suited to individual entrants.

RESETTLEMENT BY STATE

Question:

How many states have the Cuban/Haitian entrants been settled in?

Answer:

As of February 28, 1981, Cuban entrants have been resettled in all 50 states. We are currently gathering information on Haitian destinations, which we will supply to the Subcommittee as soon as it is available.

Question:

Provide for the Committee a breakdown according to your latest estimates of how many Cubans/Haitians have settled in each state?

Answer:

The table on the next page summarizes Cuban resettlements by state. We do not yet have information for Haitians.

Question:

What data does the Task Force have on the problem of secondary migration among Cuban entrants?

Answer:

The Task Force does not have information on secondary migration. A national survey on this problem was devised, but was disapproved by OMB this month.

Appendix D--Cuban Resettlements by State--As of February 28

	Resettlements	Percent of Resettlements
Alabama	118	0.1 %
Alaska	6	0.0
Arizona	176	0.1
Arkansas	380	0.3
California	5,000	4.2
Colorado	157	0.1
Connecticut	304	0.3
Delaware	20	0.0
Florida	86,356	72.7
Georgia	419	0.4
Hawaii	10	0.0
Idaho	16	0.0
Illinois	1,658	1.4
Indiana	115	0.1
Iowa	53	0.0
Kansas	171	0.1
Kentucky	36	0.0
Louisiana	797	0.7
Maryland	309	0.3
Maine	19	0.0
Massachusetts	514	0.4
Michigan	295	0.2
Minnesota	361	0.3
Mississippi	20	0.0
Missouri	189	0.2
Montana	5	0.0
Nebraska	97	0.1
Nevada	368	0.3
New Hampshire	6	0.0
New Jersey	7,675	6.5
New Mexico	246	0.2
New York	6,056	5.1
North Carolina	56	0.0
North Dakota	9	0.0
Ohio	170	0.1
Oklahoma	344	0.3
Oregon	186	0.2
Pennsylvania	1,058	0.9
Rhode Island	70	0.1
South Carolina	37	0.0
South Dakota	9	0.0
Tennessee	173	0.1
Texas	1,605	1.4
Utah	90	0.1
Vermont	4	0.0
Virginia	229	0.2
Washington	102	0.1
Washington D.C.	330	0.3
West Virginia	37	0.0
Wisconsin	908	0.8
Wyoming	18	0.0
Puerto Rico	944	0.8
Other Countries	69	0.1
Unknown	399	0.3
Total	118,799	99.9%

This information is based on sponsor location, and, due to secondary migration, may not reflect actual residence.

CHIEF (DSAD)

SOCIAL SERVICES

Question:

How many of these entrants have any knowledge of english?

Answer:

Approximately 6,200 Cubans had some english language capability when they arrived in the United States and another 4,000 benefited from attending classes in english as a second language while at the processing centers. We do not yet have hard information on the english capabilities of Haitian arrivals, although our preliminary observation is that less than 2% have some knowledge of english.

ASSISTANCE ESTIMATES

Question:

How many of the Cubans and Haitians who entered this country in the past year are working? By this I mean holding jobs, not merely that they are not receiving federal assistance.

Answer:

We do not have data on how many entrants are holding jobs.

Question:

What percentage, roughly, of these entrants do not have relatives in this country?

Answer:

Less than 50% of the Cubans reported that they do not have relatives in this country. We do not yet have data for Haitian entrants.

SUBCOMMITTEE RECESS

Senator CHILES. The committee will be in recess until 2 o'clock on Wednesday.

[Whereupon, at 11:45 a.m., Friday, March 6, the subcommittee was recessed, to reconvene at 2 p.m., Wednesday, April 1.]

[CLERK'S NOTE.—The April 1 and April 8, 1981 testimony of the Secretary of the Department of Health and Human Services will follow.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

WEDNESDAY, APRIL 1, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:40 a.m., in room 114 of the Everett McKinley Dirksen Senate Office Building, Hon. Harrison Schmitt (chairman) presiding.

Present: Senators Schmitt, Hatfield, Abdnor, Rudman, and Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF RICHARD S. SCHWEIKER, SECRETARY

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The subcommittee will come to order. Today it is my pleasure and, I believe, the subcommittee's pleasure to hear from an old friend and former colleague, I hope still a colleague of sorts, Richard S. Schweiker, who is now Secretary of the Department of Health and Human Services.

As a recent Member of the U.S. Senate, the Secretary was also a member of the Senate Appropriations Committee and ranking minority member of this subcommittee, Labor, Health and Human Services, and Education.

Secretary Schweiker presides over one of the largest Departments of the Federal Government with a budget of more than $200 billion annually and a work force of more than 140,000 people.

Today's hearing is part of our subcommittee's effort to evaluate the many budget changes which have been proposed by the new administration as well as the overall activities of the Department. We will cover not just the fiscal 1982 budget requests but also fiscal 1981 supplementals and proposed rescissions.

Mr. Secretary, I hope we can move rapidly, but we have made time available for and I believe you have agreed to another hearing or two if that's required. Welcome back to the old subcommittee.

You may proceed to organize your presentation as you see fit, and we will then proceed with questions.

Secretary SCHWEIKER. Thank you, Mr. Chairman.

First, I want to congratulate you on assuming the chairmanship of this committee. I must say I have some mixed feelings about that, since if I had stayed, I'd be sitting in your shoes, and I appreciate the opportunity——

Senator SCHMITT. Why do you think we recommended you for the job you have? [Laughter.]

Secretary SCHWEIKER. That's why I said I have some mixed feelings. I'm delighted, though, to come back to see you in the chair and to see our top staff person heading the operation here. I'm very pleased to see that and also to have a chance to renew our friendship. I just want to say I want to compliment you, Mr. Chairman. I think you have taken your duties very seriously. I know you have delved very deeply into your new assignment. Since it's a big committee with a lot of expenditures and oversight responsibility, I think that's a very commendable approach. We are certainly glad to have that conscientious and dedicated approach.

PREPARED STATEMENT

I have a long statement that I will ask to be put in the record. I also have a relatively short statement with a few charts that will summarize, I think, the main thrust of my presentation. Then I will be glad to have questions.

Senator SCHMITT. That statement and charts will be placed in the record in its entirety without objection.

[The statement and charts follow:]

Statement of Richard S. Schweiker

It is a pleasure to appear before you today to discuss the President's budget proposals for 1981 and 1982 for the Department of Health and Human Services.

This budget for 1982 totals $255.3 billion in budget authority and $250.7 billion in outlays, increases of $27.5 billion and $21.5 billion respectively above 1981. While this budget contains increases and decreases, this net increase is necessary to preserve and maintain this Department's commitment to social safety net programs. Provision of these benefits to those most in need is one of the President's highest priorities.

As you know, the HHS budget consists of authority to spend trust funds, which is not subject to the appropriations process, as well as regular appropriations requests. Our appropriations request for 1982 is $65.6 billion for the Department's programs considered by this Committee, a net increase of $4.9 billion over the 1981 level.

Our budget is an essential part of the President's program for economic recovery. As we discuss the specific proposals, we must keep in mind the importance of this program -- the total package of initiatives designed to restore the health and vigor of the national economy. We must not lose sight of the benefits that will accrue to all citizens with enactment of the President's program. For this program to succeed, budget control is essential.

The revised budget for this Department is consistent with the principal goals of the President:

o First, it maintains our Nation's commitment to protecting benefits for retired workers and assisting those most in need of support from the Federal Government;

- Second, it slows the growth of Federal spending to move toward a balanced budget; and
- Third, it restores the States and their local governments to full and effective partnership in the Federal system.

The budget I present today reflects the significant policy changes needed to achieve these goals. Our budget and legislative proposals emphasize:

- Preservation of the social safety net that provides retirement insurance benefits for the elderly and income support for dependent families, the elderly and disabled. The 1982 outlays for these programs increase by $22.7 billion, 10.5 percent over 1981.

  Social Security and Supplemental Security Income benefits are continued with full cost-of-living increases and the Medicare program is maintained at current levels with costs adjusted for projected price increases.

- Reform of entitlement programs to eliminate unintended benefits and to avoid unnecessary costs. Legislation will be proposed to limit unconstrained growth in the Medicaid program, to assure that the Aid to Families with Dependent Children (AFDC) program is available only to those most in need, to eliminate certain secondary Social Security benefits, and to tighten eligibility for Disability Insurance.

- Consolidation of categorical programs into block grants. The budget proposes consolidating 40 categorical health and social service programs into four block grants: health services, preventive health services, social services, and energy and emergency assistance.

  These proposals embody our philosophy that assistance funds can be used most effectively when the States have

THE FLEXIBILITY TO RESPOND TO STATE AND LOCAL CONDITIONS, AND THAT THE MOST EFFECTIVE FEDERAL ROLE IS TO SERVE THE STATES AND LOCALITIES IN THIS EFFORT THROUGH RESEARCH AND OTHER SUPPORT ACTIVITIES.

THE PROPOSED 1982 FUNDING LEVEL IS 75 PERCENT OF 1981 CURRENT SERVICES. THE BLOCK GRANTS WILL RESULT IN A SIGNIFICANT REDUCTION IN FEDERAL ADMINISTRATIVE OVERHEAD. FUNDING FOR THESE BLOCK GRANTS IS BEING REQUESTED THROUGH THE APPROPRIATIONS PROCESS, CONCURRENT WITH CONSIDERATION OF PROPOSED LEGISLATION. APPROPRIATIONS WOULD, OF COURSE, BE CONTINGENT UPON THE ENACTMENT OF NEW LEGISLATION. NO FUNDS ARE BEING SOUGHT FOR ANY OF THE PROGRAM AUTHORITIES BEING CONSOLIDATED.

- REDUCTION, ELIMINATION OR POSTPONEMENT OF PROGRAMS. EVERY PROGRAM IN THE DEPARTMENT HAS BEEN SUBJECT TO INTENSE SCRUTINY AND RECONSIDERATION, GIVEN THE OVERALL FISCAL SITUATION AND THE NEED TO REASSESS WHAT RESPONSIBILITIES PROPERLY FALL WITHIN THE PURVIEW OF THE FEDERAL GOVERNMENT.

  THE MAJOR DECREASES RESULTING FROM THIS SCRUTINY INCLUDE THE CLOSURE OF THE PUBLIC HEALTH SERVICE HOSPITALS AND TERMINATION OF FREE GOVERNMENT HEALTH CARE FOR MERCHANT SEAMEN; THE PHASE-OUT OF THE HEALTH PLANNING AND PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS PROGRAMS; THE PHASE-OUT OF GRANTS AND NEW LOANS FOR HEALTH MAINTENANCE ORGANIZATIONS BY THE END OF 1983; AND STREAMLINING OF SUPPORT FOR HEALTH PROFESSIONS TRAINING.

- REDUCTION OF FEDERAL PERSONNEL COSTS AND ADMINISTRATIVE OVERHEAD. THESE PROGRAM REDUCTIONS AND TERMINATIONS WOULD RESULT IN A DECREASE IN ASSOCIATED FEDERAL STAFFING OF NEARLY 8,900 FULL-TIME PERMANENT POSITIONS FOR THE TWO YEARS ENDING IN 1982. IN ADDITION, TRAVEL, CONSULTANT SERVICES, EQUIPMENT PROCUREMENT, AND OTHER ITEMS OF OVERHEAD ARE ALSO BEING DECREASED.

I WILL NOW DETAIL THE SPECIFICS OF THE BUDGETS OF EACH OF THE DEPARTMENT'S OPERATING COMPONENTS. ALTHOUGH PRIMARY EMPHASIS WILL BE PLACED ON ITEMS THAT COME BEFORE THIS SUBCOMMITTEE, I WILL DISCUSS OTHER ITEMS IN ORDER TO PUT THE HHS BUDGET IN A MORE COMPLETE PERSPECTIVE.

PUBLIC HEALTH SERVICE

FOR PUBLIC HEALTH SERVICE PROGRAMS WITHIN THIS SUBCOMMITTEE'S JURISDICTION, WE ARE REQUESTING APPROPRIATIONS OF $6,460 MILLION, A DECREASE OF $394 MILLION FROM THE 1981 REVISED LEVEL. THIS BUDGET EMBODIES SIGNIFICANT REDIRECTION OF THE WIDE ARRAY OF DISCRETIONARY HEALTH PROGRAMS WHICH WERE DEVELOPED AND HAVE GROWN SUBSTANTIALLY OVER THE PAST DECADE.

FOREMOST IS THE PROPOSAL TO CONSOLIDATE 26 CATEGORICAL GRANT PROGRAMS INTO TWO STATE BLOCK GRANTS -- HEALTH SERVICES AND PREVENTION. BY COMBINING THE CURRENT MIX OF COMPLEX AND OVERLAPPING GRANTS INTO TWO COMPREHENSIVE FUNDING PACKAGES, STATES WILL HAVE THE MANAGERIAL AND POLICY FLEXIBILITY TO RESPOND APPROPRIATELY TO THEIR MOST PRESSING HEALTH NEEDS. THE 1982 BUDGET INCLUDES $1.4 BILLION FOR THE TWO HEALTH BLOCK GRANTS: $1.1 BILLION FOR HEALTH SERVICES AND $0.3 BILLION FOR PREVENTION ACTIVITIES.

A SECOND PROPOSAL IS TO ELIMINATE THE CURRENT SYSTEM OF PROVIDING FREE GOVERNMENT HEALTH CARE SERVICES TO MERCHANT SEAMEN AND THUS CLOSE THE PUBLIC HEALTH SERVICE HOSPITALS. AT PRESENT THE PHS OPERATES EIGHT GENERAL HOSPITALS AND TWENTY-SEVEN CLINICS, WHICH EMPLOY OVER 5,500 DOCTORS, NURSES, TECHNICIANS AND SUPPORT STAFF TO PROVIDE THIS SUBSIDIZED CARE. THIS SYSTEM EVOLVED FROM A TIME WHEN AMERICAN PORT CITIES HAD INADEQUATE MEDICAL SERVICE TO PROTECT THE PUBLIC FROM COMMUNICABLE DISEASES CARRIED BY SEAMEN. TODAY, THE HOSPITALS ARE UNDER-USED, AND MANY ARE LOCATED IN AREAS WITH AN EXCESS SUPPLY OF HOSPITAL BEDS. WE

ARE SEEKING YOUR CONCURRENCE IN CLOSING THE HOSPITAL AND CLINIC SYSTEM BY INCLUDING IN APPROPRIATION LANGUAGE A PROVISION WHICH WOULD DELETE THE CURRENT STATUTORY MANDATE TO MAINTAIN SERVICES AT THE LEVEL PROVIDED IN 1973. ALSO, SEPARATE LEGISLATION TO ACHIEVE THIS PURPOSE WILL BE SUBMITTED TO THE CONGRESS.

IN ORDER TO ELIMINATE UNNECESSARY FEDERAL SUBSIDIES, WE PROPOSE TO PHASE OUT THE FEDERAL GRANT AND LOAN SUBSIDY PROGRAM TO HEALTH MAINTENANCE ORGANIZATIONS (HMOS). THERE ARE NOW IN THE UNITED STATES 235 HMOS WITH 9 MILLION MEMBERS. OF THESE, ABOUT TWO-THIRDS HAVE BEEN INITIATED WITHOUT FEDERAL DOLLARS. THE GROWING PUBLIC RECOGNITION AND ACCEPTANCE OF HMOS, WHICH WAS AN UNTRIED APPROACH TO THE DELIVERY OF HEALTH SERVICES IN MANY PARTS OF THE COUNTRY UNTIL RECENTLY, ELIMINATES THE NEED FOR ADDITIONAL FEDERAL FINANCIAL INCENTIVES TO SPUR DEVELOPMENT OF THIS ONCE FLEDGLING INDUSTRY. TO IMPROVE THE COMPETITIVENESS OF HMOS, WE WILL PROPOSE LEGISLATION TO MODIFY UNNECESSARILY RESTRICTIVE REQUIREMENTS FOR FEDERAL QUALIFICATIONS CURRENTLY FOUND IN THE HEALTH MAINTENANCE ORGANIZATIONS ACT.

AS PART OF OUR GOVERNMENT-WIDE EFFORT TO STIMULATE GREATER COMPETITION WITHIN THE HEALTH CARE INDUSTRY, WE WOULD PHASE OUT THE FEDERALLY FUNDED HEALTH PLANNING PROGRAM. THE 213 LOCAL HEALTH SYSTEMS AGENCIES AND 57 STATE PLANNING ORGANIZATIONS HAVE IMPOSED ADDITIONAL REGULATORY BURDENS ON THE INDUSTRY WITH LITTLE APPARENT IMPACT ON CONTROLLING HEALTH COST INCREASES NATIONALLY.

TO PREVENT UNNECESSARY PROGRAM GROWTH AND COSTS, THE BUDGET FOR 1981 AND 1982 PROPOSES TO ELIMINATE FUNDING FOR NEW NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS. THE RECENT GROWTH IN THE AGGREGATE SUPPLY OF DOCTORS HAS CAUSED PHYSICIANS INCREASINGLY TO LOCATE NEW PRACTICES IN MANY UNSERVED OR UNDERSERVED AREAS. THIS HAS MITIGATED THE NEED FOR CONTINUED EXPANSION OF THE NATIONAL HEALTH SERVICE CORPS (NHSC) FIELD PROGRAM. THUS, THE PROGRAM IS BEING LIMITED TO A FIELD STRENGTH OF 2,500, AN INCREASE

OF 450 ASSIGNEES ABOVE 1981, WHICH WOULD MEET THE NEEDS OF THE MOST CRITICALLY UNDERSERVED AREAS OF THIS COUNTRY INCLUDING THOSE IN URBAN AREAS. SCHOLARSHIPS WILL CONTINUE TO BE AWARDED TO STUDENTS CURRENTLY RECEIVING THEM. THOSE STUDENTS ALREADY IN THE "PIPELINE" WILL BE SUFFICIENT TO MAINTAIN A CORPS OF 2,500 FOR THE NEAR FUTURE.

THE FEDERAL GOVERNMENT IS THE PRINCIPAL SOURCE OF FUNDING FOR BIOMEDICAL RESEARCH IN THIS COUNTRY. THE RESEARCH BUDGETS FOR THE NATIONAL INSTITUTES OF HEALTH (NIH) AND ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA) TOTAL $3.98 BILLION IN 1982, AN INCREASE OF $255 MILLION OVER 1981, AND REFLECT OUR COMMITMENT TO MAINTAINING A STRONG NATIONAL BIOMEDICAL RESEARCH ENTERPRISE.

RESEARCH PROJECT GRANTS, THE PRIMARY VEHICLE FOR STIMULATING SCIENTIFIC DEVELOPMENT, WILL BE FUNDED AT $2.1 BILLION IN 1982. THIS WOULD PERMIT THE AWARD OF 4,900 NEW GRANTS IN NIH AND 545 IN ADAMHA. FUNDS ARE ALSO INCLUDED TO SUPPORT 11,310 RESEARCH TRAINEES; HOWEVER, PAYMENTS TO TRAINING INSTITUTIONS FOR SUPPORT COSTS OVER AND ABOVE NORMAL TUITION, FEES, AND LIVING EXPENSES FOR THE INDIVIDUAL RECIPIENTS WOULD BE ELIMINATED.

WE PLAN TO REFOCUS FEDERAL AID FOR THE TRAINING OF HEALTH PROFESSIONALS, AND THE BUDGET FOR 1982 INCLUDES $120 MILLION FOR THIS PURPOSE. LEGISLATION IS BEING PROPOSED TO TARGET LIMITED SUPPORT ON NATIONAL PRIORITY MEDICAL AND NONPHYSICIAN SPECIALITIES WHERE SHORTAGES PERSIST. THE SUPPLY OF HEALTH PROFESSIONALS HAS INCREASED SIGNIFICANTLY OVER THE PAST 20 YEARS, AND THE NEED FOR FURTHER FEDERAL INCENTIVES TO INCREASE THE OVERALL NATIONAL SUPPLY NO LONGER EXISTS.

IN CONJUNCTION WITH THE REQUEST TO ESTABLISH BLOCK GRANTS AND OTHER PROPOSED BUDGET REDUCTIONS, WE HAVE REQUESTED A 1981 SUPPLEMENTAL OF $121 MILLION FOR PROGRAM TERMINATION EXPENSES. THESE FUNDS WOULD BE AVAILABLE FOR THREE YEARS AND WILL COVER PERSONNEL SEVERANCE COSTS AND THE COSTS OF TEMPORARY ARRANGEMENTS

TO MAINTAIN CERTAIN PROGRAM SERVICES UNTIL TERMINATION IS COMPLETED.

HEALTH CARE FINANCING ADMINISTRATION

THE 1982 BUDGET FOR THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) INCLUDES OUTLAYS OF $64.5 BILLION FROM BOTH TRUST FUNDS AND APPROPRIATIONS. THIS IS AN INCREASE OF 12 PERCENT OVER THE CURRENT ESTIMATE FOR 1981. APPROXIMATELY 48 MILLION BENEFICIARIES WILL RECEIVE HEALTH CARE SERVICES THROUGH THE MEDICAID AND MEDICARE PROGRAMS IN 1982, AN INCREASE OF MORE THAN ONE MILLION OVER 1981.

FOR HCFA PROGRAMS WHICH REQUIRE APPROPRIATIONS ACTION, PRIMARILY MEDICAID AND A PORTION OF THE MEDICARE PROGRAM, WE ARE REQUESTING $33 BILLION IN 1982.

THE 1982 APPROPRIATIONS REQUEST FOR THE MEDICAID PROGRAM UNDER CURRENT LAW IS $18.4 BILLION, AN INCREASE OF $1.8 BILLION OVER THE REVISED ESTIMATE FOR 1981. THIS ESTIMATE IS BASED ON THE AGGREGATE OF THE NOVEMBER STATES' ESTIMATES FOR MEDICAID VENDOR PAYMENTS, STATE AND LOCAL ADMINISTRATION AND STATE CERTIFICATION OF MEDICAID PROVIDERS. THIS APPROPRIATIONS REQUEST DOES NOT REFLECT THE EFFECT OF OUR PROPOSED "CAP" ON MEDICAID WHICH REQUIRES LEGISLATIVE ACTION.

A TOTAL OF $14.5 BILLION IS REQUESTED FOR PAYMENTS TO THE HEALTH CARE TRUST FUNDS, AN INCREASE OF ALMOST $5 BILLION OVER 1981. MOST OF THIS INCREASE IS FOR FEDERAL MATCHING OF PREMIUMS PAID BY OR FOR INDIVIDUALS ENROLLED IN THE SUPPLEMENTARY MEDICAL INSURANCE (SMI) PROGRAM. THE GROWTH IN THE FEDERAL PAYMENT FOR THE SMI PROGRAM IS DUE PRIMARILY TO RISING PROGRAM COSTS, STATUTORY LIMITATIONS ON PREMIUM INCREASES, AND THE NEED FOR A CONTINGENCY MARGIN TO KEEP THE PROGRAM ACTUARIALLY SOUND IN THE FUTURE.

THE 1982 REVISED BUDGET ALSO CONTAINS A NUMBER OF PROGRAM INNOVATIONS DESIGNED TO BEGIN REFORM OF THE FINANCING FOR HEALTH CARE SERVICES.

Chief among these initiatives is the proposal to establish an interim limit (a "cap") on Federal support for Medicaid. This arrangement would replace the current system of open-ended Federal payments to States, which has contributed to Medicaid expenditure increases of more than 15 percent each year for the last five years. By limiting Federal expenditures, States will have additional incentives to reduce abuse and waste and to provide services on a more cost-effective basis to those most in need.

This legislation will also give States additional flexibility to develop innovative methods for the financing and delivery of services. This expanded authority, combined with legislative initiatives in the AFDC program designed to target welfare assistance more closely to those in greatest need, is intended to permit States to reorganize their programs and control Medicaid costs.

Our proposal which has an effective date of July 1, 1981, would result in 1982 savings of $1 billion.

Over the next two years, the Administration plans to develop and begin implementation of a pro-competition legislative package that would reform the way health care services are reimbursed and delivered. These reforms will be comprehensive and will address such issues as employer contributions to employee health insurance and the marketing of health insurance plans that promote cost-conscious behavior.

Our budget also contains other legislative proposals designed to increase the cost-effectiveness of Medicaid and Medicare. It includes repeal of several low-priority benefit expansions adopted by the Congress in the 1980 Omnibus Reconciliation Act, and the establishment by regulation of a single reimbursement rate for all providers of chronic renal dialysis. The repeal of Reconciliation Act provisions would avoid Federal costs of $0.7 billion in 1982. The revision of reimbursement rates for chronic renal dialysis, which would

ELIMINATE AN UNJUSTIFIED PAYMENT DIFFERENTIAL FOR MANY HOSPITAL-BASED PROVIDERS, WOULD RESULT IN MEDICARE SAVINGS OF $105 MILLION IN 1982.

REDUCING UNNECESSARY FEDERAL REGULATION OF THE HEALTH CARE INDUSTRY IS ANOTHER MAJOR OBJECTIVE OF THE 1982 BUDGET. AS PART OF THIS EFFORT, THE DEPARTMENT IS PROPOSING TO PHASE OUT THE PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO) BY THE END OF 1983. IN CONJUNCTION WITH THE PHASE-OUT OF THE PSRO PROGRAM, LEGISLATION WILL ALSO BE PROPOSED TO ELIMINATE THE REQUIREMENT FOR UTILIZATION REVIEW BY PROVIDERS NOT COVERED BY PSRO REVIEW.

ELIMINATION OF FEDERAL REGULATION IN THIS AREA WILL ALLOW THE STATES AND PRIVATE HEALTH CARE PROVIDERS TO DETERMINE THE NEED FOR, AND THE MOST APPROPRIATE FORM OF, UTILIZATION REVIEW.

THE DEPARTMENT IS ALSO PROPOSING TO REDUCE THE FREQUENCY OF CERTIFICATION SURVEYS FOR FACILITIES PARTICIPATING IN MEDICARE AND MEDICAID. TO ENSURE THAT HEALTH AND SAFETY STANDARDS ARE MAINTAINED, SURVEYS WILL BE CONDUCTED ON A SAMPLE BASIS WITH SPECIAL ATTENTION GIVEN TO PROVIDERS WITH A HISTORY OF NON-COMPLIANCE WITH PROGRAM REQUIREMENTS.

AS PART OF A GENERAL EFFORT TO MINIMIZE ADMINISTRATIVE COSTS, THE BUDGET PROPOSES TO MAINTAIN FUNDING FOR RESEARCH AND DEMONSTRATION PROJECTS IN 1981 AND 1982 AT THE 1980 PROGRAM LEVEL OF $46 MILLION, INCLUDING $29 MILLION IN NEW 1982 BUDGET AUTHORITY. THE BUDGET ALSO INCLUDES REDUCTIONS IN HCFA PERSONNEL AND OPERATING EXPENSES RELATED TO THESE PROGRAM CHANGES. THESE REDUCTIONS WILL SAVE $4 MILLION AND 128 POSITIONS COMPARED TO 1981.

SOCIAL SECURITY ADMINISTRATION

THE DEPARTMENT'S INCOME SECURITY PROGRAMS -- SOCIAL SECURITY AND THE NEEDS-BASED INCOME SUPPORT PROGRAMS -- FORM AN INTEGRAL PART OF THE PRESIDENT'S SOCIAL SAFETY NET.

IN 1982, THE SOCIAL SECURITY ADMINISTRATION PROGRAMS WILL TOTAL $167.1 BILLION IN BUDGET AUTHORITY AND $172.8 BILLION IN

OUTLAYS, INCLUDING $3.6 BILLION IN PROPOSED LEGISLATIVE SAVINGS. APPROXIMATELY 90 PERCENT OF THIS TOTAL REPRESENTS TRUST FUND ACTIVITY WHICH THIS COMMITTEE DOES NOT CONSIDER. PROGRAMS WHICH REQUIRE APPROPRIATIONS ACTION ACCOUNT FOR $19.2 BILLION UNDER CURRENT LAW, PRIMARILY FOR THE SUPPLEMENTARY SECURITY INCOME (SSI) AND AFDC PROGRAMS. IN ADDITION, YOUR COMMITTEE CONSIDERS $3.3 BILLION IN TRUST FUND ADMINISTRATIVE EXPENSE LIMITATIONS.

I WOULD LIKE TO SUMMARIZE FOR YOU NOW THE MAJOR COMPONENTS OF OUR 1982 SOCIAL SECURITY BUDGET, INCLUDING HIGHLIGHTS OF THE TRUST FUND BENEFIT PROGRAMS.

SOCIAL SECURITY BENEFITS

UNDER CURRENT LAW, SOCIAL SECURITY TRUST FUND OUTLAYS WILL INCREASE BY $19.8 BILLION IN 1982. CONTINUED GROWTH IN PROGRAM COSTS IS DUE LARGELY TO TWO FACTORS: EXPANDING BENEFICIARY POPULATION (UP OVER HALF A MILLION IN 1982), AND HIGHER BENEFIT LEVELS, PRINCIPALLY DUE TO COST-OF-LIVING INCREASES (11.2 PERCENT ESTIMATED FOR JUNE 1981, AND 9.3 PERCENT ESTIMATED FOR JUNE 1982).

THE 1982 REVISED BUDGET PROPOSES SEVERAL REVISIONS TO THE SOCIAL SECURITY BENEFIT STRUCTURE AS PART OF THE PRESIDENT'S ECONOMIC REVITALIZATION PROGRAM. THE PROPOSED REFORMS HAVE BEEN DESIGNED TO ASSURE THAT BASIC SOCIAL SECURITY COVERAGE IS PROTECTED AND THAT PROGRAM ALTERNATIVES ARE AVAILABLE TO MINIMIZE THE IMPACT OF CHANGES ON LOW-INCOME BENEFICIARIES.

IN TOTAL, OUR RECOMMENDATIONS WITH RESPECT TO SOCIAL SECURITY ARE ESTIMATED TO YIELD ABOUT $2.2 BILLION IN 1982 SAVINGS, INCLUDING OFFSETTING ADMINISTRATIVE EXPENSES AND INCREASED SSI PAYMENTS. IN 1986, SAVINGS TO THE TRUST FUNDS WOULD TOTAL $5.5 BILLION WITH ENACTMENT OF THIS LEGISLATIVE PROGRAM.

REPEAL OF THE MINIMUM BENEFIT AND THE CAP ON BENEFITS PAYABLE FROM MULTIPLE DISABILITY PAYMENT SOURCES ARE EXAMPLES OF

PROGRAM MODIFICATIONS DESIGNED TO BRING PAYMENTS INTO A BETTER RELATIONSHIP WITH RECIPIENTS' EARNINGS HISTORIES. THE SSI PROGRAM WILL PROVIDE A DOLLAR-FOR-DOLLAR OFFSET FOR LOW-INCOME PERSONS. PHASE-OUT OF THE AGE 18-21 STUDENT DEPENDENTS' BENEFIT ELIMINATES A PROGRAM WHICH WAS ADDED TO THE SOCIAL SECURITY SYSTEM IN THE CONTEXT OF 1960'S FEDERAL EDUCATIONAL POLICY, AND WHEN IT WAS THOUGHT THAT THE SOCIAL SECURITY SYSTEM HAD EXCESS RESOURCES. COMPREHENSIVE STUDENT AID, INCLUDING OUTRIGHT GRANTS AS WELL AS LOANS, WILL CONTINUE TO BE AVAILABLE FOR ALL NEEDY STUDENTS THROUGH PROGRAMS OF THE DEPARTMENT OF EDUCATION.

THESE AND THE OTHER BENEFIT CHANGES ELIMINATE PERIPHERAL, SPECIAL AND OUTMODED SOCIAL SECURITY PROVISIONS, REDUCE FEDERAL SPENDING REQUIREMENTS AND, AT THE SAME TIME, HELP TO ASSURE THE AVAILABILITY OF RESOURCES FOR CORE SOCIAL SECURITY PROTECTION.

IMPLEMENTING THESE LEGISLATIVE REFORMS WILL BE A MAJOR UNDERTAKING FOR THE SOCIAL SECURITY ADMINISTRATION, REQUIRING CAREFUL PLANNING, NEW EMPLOYEE HIRING AND TRAINING, AND MANY SYSTEMS CHANGES. IN THIS REGARD, WE HAVE REQUESTED A PROGRAM SUPPLEMENTAL OF $67 MILLION, AND THE 1982 ADMINISTRATIVE EXPENSES BUDGET INCLUDES APPROXIMATELY $280 MILLION TO ACCELERATE REVIEWS OF DISABILITY CASES NOW ON THE ROLLS AND TO MAKE THE NEEDED SYSTEMS IMPROVEMENT ESSENTIAL TO SUCCESSFUL IMPLEMENTATION OF THESE LEGISLATIVE CHANGES.

I WOULD ALSO HIGHLIGHT ONE MAJOR PIECE OF UNFINISHED BUSINESS WHICH IS RECEIVING THE HIGHEST PRIORITY ATTENTION FROM THIS ADMINISTRATION. AS YOU ARE AWARE, OUTLAYS FROM THE OLD AGE AND SURVIVORS' INSURANCE (OASI) TRUST FUND ARE ESTIMATED TO EXCEED INCOME UNDER CURRENT LAW IN 1982. THE ADMINISTRATION BELIEVES A COMPREHENSIVE REFORM OF SOCIAL SECURITY FINANCING IS NECESSARY TO INSURE ADEQUATE PAYMENTS. AN INTERDEPARTMENTAL TASK FORCE IS CURRENTLY WORKING TO

DEVELOP SUCH A REFORM PACKAGE FOR PRESENTATION TO CONGRESS IN THE NEAR FUTURE.

INCOME-TESTED PROGRAMS

NEEDS-BASED INCOME SUPPORT PROGRAMS FOR WHICH APPROPRIATIONS ARE REQUESTED INCLUDE: SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED; AID TO FAMILIES WITH DEPENDENT CHILDREN, PRINCIPALLY FOR SINGLE-PARENT FAMILIES WITH CHILDREN, AND CHILD SUPPORT ENFORCEMENT; AND THE PROPOSED ENERGY AND EMERGENCY ASSISTANCE BLOCK GRANT. IN ADDITION, WE ARE ALSO SEEKING FUNDING FOR MAKING PAYMENTS FOR COAL MINERS DISABLED BY BLACK LUNG DISEASE AND THEIR SURVIVORS.

THE MAJOR POLICY RECOMMENDATIONS FOR THESE PROGRAMS INCLUDE THE CONSOLIDATION OF ENERGY AND EMERGENCY ASSISTANCE INTO A BLOCK GRANT AND A SERIES OF PROPOSED ELIGIBILITY MODIFICATIONS IN THE AFDC PROGRAM.

THE EMERGENCY AND ENERGY ASSISTANCE BLOCK GRANT PROPOSAL CONSOLIDATES THE LOW-INCOME ENERGY ASSISTANCE PROGRAM WHICH EXPIRES AT THE END OF THIS YEAR AND THE EMERGENCY ASSISTANCE PROGRAM UNDER TITLE IV OF THE SOCIAL SECURITY ACT. UNDER THIS PROPOSAL, STATES WOULD HAVE COMPLETE FLEXIBILITY TO DETERMINE PROGRAMS OF FUEL ASSISTANCE AND OTHER CRISIS OR EMERGENCY NEEDS FOR THEIR LOW-INCOME HOUSEHOLDS. THE 1982 BUDGET INCLUDES $1.4 BILLION FOR THIS BLOCK GRANT, REQUESTED AS A CONTINGENCY APPROPRIATION TO BE ENACTED CONCURRENT WITH CONSIDERATION OF AUTHORIZING LEGISLATION.

A MAJOR LEGISLATIVE INITIATIVE IS BEING PROPOSED FOR THE AFDC PROGRAM TO TARGET MORE EFFECTIVELY WELFARE ASSISTANCE ON THOSE MOST IN NEED, TO REDUCE INCENTIVES FOR REMAINING ON ASSISTANCE, AND TO IMPROVE PROGRAM MANAGEMENT. THESE AND OTHER CHANGES WILL RESULT IN AN ESTIMATED $1.0 BILLION IN FEDERAL SAVINGS IN 1982, GROWING TO $1.3 BILLION BY 1986. STATE AND LOCAL GOVERNMENT SAVINGS ARE EXPECTED TO TOTAL APPROXIMATELY

$850 MILLION IN 1982. THE APPROPRIATIONS REQUEST PENDING BEFORE THE CONGRESS NOW, HOWEVER, IS BASED ON CURRENT LAW. AFTER ENACTMENT OF SPECIFIC LEGISLATIVE CHANGES, WE WILL SEEK APPROPRIATE MODIFICATIONS TO THE 1982 SPENDING LEVELS. THE MAJOR PROVISIONS ARE:

- PAYMENT OF THE EARNED INCOME TAX CREDIT (EITC) WILL BE ASSUMED FOR ALL ELIGIBLE FAMILIES AND TREATED AS EARNED INCOME IN CALCULATING BENEFITS.
- IN DETERMINING ELIGIBILITY FOR AND THE AMOUNT OF MONTHLY BENEFITS, WORK EXPENSES WILL BE STANDARDIZED AT $75, CHILD CARE COSTS WILL BE CAPPED AT $50 PER CHILD, AND APPLICATION OF THE $30 AND ONE-THIRD EARNED INCOME DISREGARD WILL BE MODIFIED. IN ADDITION, A MAXIMUM ELIGIBILITY CAP FOR EARNINGS WILL BE SET AT 150 PERCENT OF THE STATE'S NEED STANDARD.
- STATES WILL BE REQUIRED TO COUNT THE INCOME OF A STEP-PARENT OR THOSE ASSUMING THE ROLE OF STEP-PARENTS IN DETERMINING AFDC ELIGIBILITY AND PAYMENT AMOUNTS AND STATES WILL BE PERMITTED TO REDUCE THE AFDC GRANT BY THE AMOUNT OF FOOD STAMP AND HOUSING ASSISTANCE SUBSIDIES WHICH DUPLICATE THE FOOD AND SHELTER COMPONENTS OF AFDC.
- ALL STATES WILL BE REQUIRED TO ADOPT PERIODIC REPORTING AND THE RETROSPECTIVE SYSTEM OF REFLECTING CHANGES IN RECIPIENTS' EARNINGS AND OTHER FACTORS AFFECTING PROGRAM ELIGIBILITY.
- FEDERAL MATCHING FOR TRAINING COSTS RELATED TO THE ADMINISTRATION OF AFDC WILL BE REDUCED TO THE REGULAR 50 PERCENT ADMINISTRATIVE EXPENSES MATCHING RATE.
- PAYMENTS WILL BE TERMINATED FOR DEPENDENT CHILDREN AT AGE 18, UNLESS THE CHILD IS IN THE LAST YEAR OF HIGH SCHOOL, AND PERSONS PARTICIPATING IN LABOR DISPUTES OTHER THAN EMPLOYER LOCKOUTS WILL NO LONGER BE ELIGIBLE.

- o STATES WILL BE REQUIRED TO ESTABLISH "WORKFARE" PROGRAMS WHICH WILL REQUIRE RECIPIENTS IN CATEGORIES EXPECTED TO WORK TO ACCEPT PRIVATE SECTOR JOBS OR COMMUNITY WORK ASSIGNMENTS.

- o THE UNEMPLOYED PARENT PROGRAM WILL BE MODIFIED TO DEFINE ELIGIBILITY BASED ON THE PARENT WHO IS THE PRIMARY WAGE EARNER.

THE 1982 BUDGET ALSO INCLUDES A NUMBER OF LEGISLATIVE PROPOSALS DESIGNED TO INCREASE CHILD SUPPORT ENFORCEMENT PROGRAM COLLECTIONS AND MAKE THE SHARING OF NET PROGRAM COSTS BETWEEN THE FEDERAL GOVERNMENT AND STATE GOVERNMENTS MORE EQUITABLE.

- o STATES WOULD BE AUTHORIZED TO COLLECT SPOUSAL SUPPORT WHEN COURT ORDERS INCLUDE SUPPORT FOR A CHILD'S CARETAKER RELATIVE;

- o STATES WILL BE REQUIRED TO RETAIN UP TO 10 PERCENT OF COLLECTIONS MADE ON BEHALF OF NON-AFDC FAMILIES AS A FEE TO COVER THE COST OF THE SERVICE;

- o AN AMENDMENT TO THE BANKRUPTCY ACT WILL BE PROPOSED TO PROHIBIT THE DISCHARGE OF CHILD SUPPORT OBLIGATIONS THROUGH BANKRUPTCY PROCEEDINGS;

- o THE INTERNAL REVENUE SERVICE WILL BE REQUIRED TO INTERCEPT FEDERAL INCOME TAX REFUNDS TO COLLECT CHILD SUPPORT ARREARAGES FROM LIABLE ABSENT PARENTS PURSUANT TO A LEGAL SUPPORT OBLIGATION; AND

- o THE INCENTIVE PAYMENT FORMULA WILL BE REVISED SO THAT THESE PAYMENTS ARE DEDUCTED FROM BOTH THE STATE AND FEDERAL SHARE OF COLLECTIONS RATHER THAN FROM ONLY THE FEDERAL SHARE OF COLLECTIONS.

OVERALL, THESE PROPOSALS, IF APPROVED BY THE CONGRESS, WILL PROVIDE ADDITIONAL RESOURCES TO BOTH THE FEDERAL GOVERNMENT AND THE STATES: THE FEDERAL GOVERNMENT WILL MOVE

FROM AN ESTIMATED $158 MILLION LOSS TO A $15 MILLION SAVINGS POSITION AND THE STATE SAVINGS WILL INCREASE BY AN ADDITIONAL $33 MILLION.

OFFICE OF HUMAN DEVELOPMENT SERVICES

WE ARE REQUESTING $6.0 BILLION IN APPROPRIATIONS FOR SOCIAL SERVICE PROGRAMS TO BE ADMINISTERED BY THE OFFICE OF HUMAN DEVELOPMENT SERVICES IN 1982, APPROXIMATELY $1.1 BILLION BELOW COMPARABLE 1981 LEVELS.

FEDERAL SPENDING ON SOCIAL SERVICES HAS GROWN RAPIDLY IN RECENT YEARS, AND NEW APPROACHES TO PROVIDING THESE SERVICES ARE ESSENTIAL. IN THIS CONTEXT, THE MAJOR FOCUS IN THE 1982 BUDGET REVISIONS IS ON INCREASING STATE FLEXIBILITY IN THE PROGRAMMING AND ADMINISTRATION OF RESOURCES. THIS OBJECTIVE IS BEING CARRIED OUT THROUGH:

- CONSOLIDATION OF THE MAJOR FEDERAL SOCIAL SERVICE AUTHORITIES, INCLUDING TITLE XX, CHILD WELFARE, FOSTER CARE, REHABILITATION SERVICES AND COMMUNITY SERVICES INTO A SINGLE, FLEXIBLE BLOCK GRANT TO THE STATES.
- CONSOLIDATION OF AGING SERVICES AND NUTRITION AND RELATED DEPARTMENT OF AGRICULTURE ACTIVITIES INTO A NEW AGING SERVICES AUTHORITY WITH INCREASED STATE FLEXIBILITY.
- CONSOLIDATION OF OTHER OHDS DISCRETIONARY AND RESEARCH AND DEMONSTRATION ACTIVITIES.

IN ADDITION, THE 1982 REVISED BUDGET ACCORDS HIGH PRIORITY TO THE HEAD START PROGRAM.

I WOULD LIKE TO BRIEFLY HIGHLIGHT THESE PROPOSALS FOR THE COMMITTEE.

SOCIAL SERVICES BLOCK GRANT

THE MAJOR PROPOSAL AFFECTING THE STRUCTURE OF SOCIAL SERVICES AND FEDERAL/STATE ADMINISTRATIVE RELATIONSHIPS IS THE RECOMMENDED CONSOLIDATION OF SERVICE ACTIVITIES INTO A

SINGLE, FLEXIBLE SOCIAL SERVICES BLOCK GRANT. IN TOTAL, THIS BLOCK GRANT WILL BE FUNDED AT $3.8 BILLION IN 1982, APPROXIMATELY 75 PERCENT OF THE $5.0 BILLION 1981 FUNDING LEVEL FOR THE CATEGORICAL PROGRAMS PROPOSED FOR INCLUSION IN THE GRANT.

THIS BLOCK GRANT WILL PROVIDE FOR THE SAME TYPES OF ACTIVITIES NOW FUNDED ON A CATEGORICAL BASIS AS WELL AS SUCH RELATED ACTIVITIES AS LEGAL SERVICES FOR THE POOR WHICH, WHILE NOT SPECIFICALLY INCLUDED FOR THE PURPOSES OF FUNDING LEVELS IN THE BLOCK GRANT, WOULD BE AUTHORIZED UNDER IT. STATES WILL NOT BE REQUIRED TO ALLOCATE FUNDING ON THE BASIS OF EITHER PROGRAM OR POPULATION EARMARKS.

THE FUNDING DISTRIBUTION TO THE STATES WILL BE PROPORTIONAL TO FUNDS ALLOCATED IN 1981, AND NO STATE MATCHING OR MAINTANENCE OF EFFORT WILL BE MANDATED.

UNDER THE BLOCK GRANT, WE WILL BE ABLE TO STREAMLINE OUR FEDERAL ADMINISTRATIVE RESPONSIBILITIES WITH SAVINGS OF OVER 200 STAFF IN 1982.

IN A COMPANION PROPOSAL TO THE BLOCK GRANT, WE ARE ALSO PROPOSING CONSOLIDATION OF SEVERAL RELATED RESEARCH AND DEVELOPMENT ACTIVITIES. THIS APPROACH IS DESIGNED TO RESPOND MORE FLEXIBLY TO STATE REQUESTS FOR INFORMATION AND ASSISTANCE TO IMPROVE THE ADMINISTRATION AND EFFECTIVENESS OF THEIR SOCIAL SERVICE PROGRAMS. THIS ACTIVITY WOULD BE FUNDED AT A LEVEL OF $61 MILLION.

AGING PROGRAMS

THE 1982 BUDGET ALSO PROPOSES $715 MILLION FOR STATE-OPERATED PROGRAMS WHICH PROVIDE NUTRITION, TRANSPORTATION, IN-HOME AND LEGAL SERVICES TO PERSONS OVER 60 YEARS OLD. THE REVISED BUDGET INCLUDES A TRANSFER TO HHS OF THE DEPARTMENT OF AGRICULTURE-ADMINISTERED FOOD COMMODITIES PROGRAM FOR THE ELDERLY. OVER 75 PERCENT OF THESE FUNDS ARE NOW USED FOR CASH PAYMENTS TO STATES RATHER THAN FOR COMMODITIES AND THERE IS, THEREFORE, NO REASON TO CONTINUE A SEPARATE PROGRAM. THIS ACTIVITY WILL BE FOLDED INTO HHS' AGING AUTHORITY IN 1982, AND FUNDS WILL BE DISBURSED TO THE STATES UNDER THE PROGRAM'S ALLOTMENT FORMULA. IN ADDITION, WE ARE PROPOSING CONSOLIDATION OF THE SEPARATE SERVICES AND NUTRITION AUTHORITIES INTO A SINGLE STATE GRANT PROGRAM AUTHORITY.

THIS FUNDING LEVEL IS SLIGHTLY MORE THAN THE 1981 LEVEL, AND IT IS EXPECTED THAT THE STATES, THROUGH THE ADDITIONAL PROGRAM FLEXIBILITY PROPOSED IN THE 1982 BUDGET, WILL BE ABLE TO MAINTAIN:

- 665 AREA AGENCIES AND 57 STATE AGENCIES;
- A FULL RANGE OF COMMUNITY SERVICES FOR THE AGED, INCLUDING INFORMATION AND REFERRAL, TRANSPORTATION AND COUNSELING FOR AN ESTIMATED 3.2 MILLION ELDERLY PERSONS WILL; AND
- AN ESTIMATED 611,000 DAILY MEALS IN BOTH CONGREGATE SITES AND THROUGH THE HOME DELIVERY PROGRAM.

HEAD START

THE PROPOSED 1982 BUDGET OF $950 MILLION, AN INCREASE OF $130 MILLION OR 16 PERCENT ABOVE THE 1981 LEVEL, WILL MAINTAIN OR IMPROVE THE QUALITY OF HEAD START SERVICES AT A PROJECTED ENROLLMENT LEVEL OF 374,300. OF THE CHILDREN SERVED BY THIS PROGRAM, 90 PERCENT ARE FROM POOR FAMILIES AND 10 PERCENT ARE HANDICAPPED. THIS PROGRAM, WHILE NOT PART OF THE SOCIAL SAFETY NET, HAS BEEN PROTECTED FROM REDUCTIONS IN THE 1982 BUDGET BY THE PRESIDENT. BOTH HE AND I SUPPORT THE CONTINUED HIGH PRIORITY WHICH THIS PROGRAM DESERVES.

OF THE $130 MILLION INCREASE, $78 MILLION IS REQUESTED AS A COST-OF-LIVING ADJUSTMENT TO MAINTAIN ENROLLMENT IN FULL-YEAR PROGRAMS AND PREVENT A FURTHER DETERIORATION OF PROGRAM QUALITY. THE BALANCE OF $52 MILLION WILL BE TARGETED FOR SPECIFIC IMPROVEMENTS IN SERVICE QUALITY, SUCH AS IMPROVED TEACHER

SALARIES, REDUCTIONS IN CLASSROOM SIZE, AND CORRECTIONS OF DEFICIENCIES IN FACILITIES.

HEAD START FUNDING INCREASES WHICH HAVE BEEN PROVIDED SINCE 1978 HAVE LARGELY BEEN USED TO OFFSET INFLATION. DESPITE THESE INCREASES, OPERATING COSTS HAVE INCREASED MORE RAPIDLY THAN AVAILABLE FUNDING. THERE IS GROWING CONCERN THAT THIS TREND, IF NOT REVERSED, WILL LEAD TO A DECLINE IN PROGRAM QUALITY.

REFUGEE AND ENTRANT PROGRAMS

THIS DEPARTMENT ALSO ADMINISTERS ASSISTANCE PROGRAMS FOR REFUGEES AND ENTRANTS. THE 1982 BUDGET INCLUDES $684 MILLION FOR THESE PROGRAMS, APPROXIMATELY $300 MILLION LESS THAN 1981. THIS REDUCTION IN FUNDING IS DUE TO THE EXPECTED RESETTLEMENT OF THE 1980 INFLUX OF CUBAN/HAITIAN ENTRANTS; IMPLEMENTATION OF A THREE-YEAR LIMIT ON ASSISTANCE ELIGIBILITY EFFECTIVE NEXT MONTH; SEVERAL ELIGIBILITY CHANGES TO CONFORM REFUGEE ASSISTANCE BENEFITS MORE CLOSELY TO THOSE AVAILABLE TO U.S. CITIZENS AND OTHER IMMIGRANTS; AND TERMINATION OF FUNDING FOR THE OLD CUBAN REFUGEE PROGRAM, WHICH HAS BEEN UNDER A PHASE-OUT SCHEDULE SINCE FY 1978.

WITHIN THE $684 MILLION REQUEST, WE ARE SEEKING $584 MILLION FOR REFUGEE ASSISTANCE, $73 MILLION FOR CUBAN/HAITIAN ENTRANT ASSISTANCE ACTIVITIES AND $27 MILLION TO COMPLETE RESETTLEMENT ACTIVITIES OF THE CUBAN/HAITIAN TASK FORCE. THE PRINCIPAL PURPOSE FOR THIS FUNDING IS TO REIMBURSE STATES FOR THEIR COSTS IN PROVIDING CASH AND MEDICAID ASSISTANCE TO NEEDY REFUGEES AND ENTRANTS.

DEPARTMENTAL MANAGEMENT

THE FY 1982 BUDGET REQUEST FOR THOSE ACTIVITIES WITHIN THE OFFICE OF THE SECRETARY TOTALS $264 MILLION. THE GENERAL DEPARTMENTAL MANAGEMENT APPROPRIATION SUPPORTS THE EXECUTIVE LEADERSHIP OF THE DEPARTMENT AS WELL AS SPECIALIZED STAFF SERVICES PERFORMED FOR THE DEPARTMENT'S PRIMARY OPERATING COMPONENTS ON A CENTRALIZED BASIS. ALSO INCLUDED WITHIN THE

$264 MILLION ARE APPROPRIATIONS FOR THE INSPECTOR GENERAL, THE OFFICE FOR CIVIL RIGHTS, AND POLICY RESEARCH.

THE FY 1982 REQUEST OF $147 MILLION FOR GENERAL DEPARTMENTAL MANAGEMENT REFLECTS PROGRAM REDUCTIONS OF $4.2 MILLION AND 130 FEWER POSITIONS, OFFSET BY INCREASES NECESSITATED BY THE IMPACT OF INFLATION. WITHIN THE TOTAL, HOWEVER, ONE CRITICAL ADMINISTRATION INITIATIVE, IMPROVED CASH MANAGEMENT, WILL BE PURSUED AT AN INCREASED LEVEL.

TO HELP FULFILL THE ADMINISTRATION'S PLEDGE TO ASSURE EFFECTIVE AND EFFICIENT GOVERNMENT, THE FY 1982 REQUEST FOR THE OFFICE OF THE INSPECTOR GENERAL PROVIDES INCREASED FUNDING LEVELS FOR THE STATE MEDICAID FRAUD CONTROL UNIT PROGRAM, INCLUDING PERMANENT INCENTIVE FUNDING BEYOND THE INITIAL FIRST THREE YEARS OF THE UNITS' OPERATIONS.

FOR THE OFFICE FOR CIVIL RIGHTS, WE ARE REQUESTING $18 MILLION WHICH WILL ENABLE THIS OFFICE TO CONTINUE TO BE RESPONSIVE TO INDIVIDUAL COMPLAINTS OF DISCRIMINATION AND TO PERFORM NECESSARY PRE-GRANT REVIEWS. A REDUCTION OF $1 MILLION IN THIS ACCOUNT REFLECTS REDUCTIONS IN FEDERAL PERSONNEL COSTS CONSISTENT WITH THE ADMINISTRATION'S COMMITMENT TO STREAMLINE ADMINISTRATIVE COSTS.

FOR POLICY RESEARCH, WE ARE REQUESTING $17 MILLION TO ENABLE US TO CONCENTRATE ON THOSE RESEARCH MATTERS OF THE HIGHEST PRIORITY TO THIS ADMINISTRATION.

THAT CONCLUDES MY STATEMENT. I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE AND LOOK FORWARD TO WORKING WITH YOU TO ACHIEVE THESE GOALS.

RICHARD S. SCHWEIKER

Secretary of Health and Human Services

Born: June 1, 1926 (Norristown, Pa.)
Education: 1944, Norristown High School (Valedictorian)
1950, B.A., Pennsylvania State University
(Phi Beta Kappa)
Military Service: 1944-46, served as electronics technician aboard aircraft carrier
Married: 1955, to Claire Coleman (five children)
Business Experience: 1950 to 1960, president of nation's largest ceramic tile manufacturer
House of Representatives: 1961 to 1969 (13th District, Pa.)
Senate: 1969 to 1981

With 20 years Congressional experience in federal health and welfare policy, Richard Schultz Schweiker was sworn in Jan. 22, 1981, as the 14th Secretary of Health and Human Services (formerly Health, Education and Welfare).

Schweiker had served eight years representing Pennsylvania's 13th District in the House of Representatives, and two six-year terms in the Senate. As senator, Schweiker was ranking Republican member of the Labor and Human Resources Committee, ranking Republican member of the Senate Health and Scientific Research Subcommittee, and ranking member on the Appropriations Subcommittee on Labor-Health and Human Services. He was in the unique position of dealing with both authorizing legislation and yearly appropriations in the areas of health, education, welfare, labor and aging, and his expertise in these areas was well-known.

An acknowledged leader in the fight against diabetes, Schweiker was the author of legislation creating the National Commission on Diabetes and the National Diabetes Advisory Board. In addition, the 96th Congress enacted his Medicaid anti-fraud amendment requiring states to use a sophisticated computer system to detect abuse in the Medicaid program.

Schweiker was also the author of comprehensive health care reform legislation, introduced in the 96th Congress, designed to both increase health care coverage and promote cost sharing and increased choice among competitive health insurance plans.

Among Schweiker's other primary legislative concerns in the health field:

— preventive health care
— cancer and heart disease research
— reform of the nation's blood program
— halting federal support for abortions
— legislation combating sickle cell anemia and lead paint poisoning

Schweiker was born June 1, 1926, in Norristown, Pa. to Malcolm Alderfer and Blanche Schultz Schweiker. He attended elementary and junior high schools in Worcester, Pa., and was Norristown High School valedictorian in 1944. He enlisted in the Navy at the age of 17 and served as an electronics technician aboard an aircraft carrier in World War II.

He received his B.A. degree from Pennsylvania State University in 1950, graduating Phi Beta Kappa.

In 1955, he married Claire Coleman (the original "Miss Claire" of the children's TV program "Romper Room"). They have five children: Malcolm C., 23; Lani Lynne, 20; Kyle Claire, 16; Richard S. Jr., 14; Lara Kristi, 11; and one grandchild.

A businessman from 1950 to 1960, he rose to president in the American Olean Tile Co. in Lansdale, Pa., the country's leading manufacturer of ceramic tile. He was active in the local Republican Party as precinct worker and committeeman, and he founded the Montgomery County (Pa.) Young Republican Club.

In 1960, when he was 34, he won election to the House of Representatives, where he served on the Government Operations and Armed Services Committees. He co-authored a book, "How to End the Draft," which presented the formula later used in creating the Volunteer Army. In addition, the "Schweiker Act" of 1965 provided for cash awards to military personnel who suggested money-saving ideas. The Schweiker Act has resulted in savings of more than $1 billion to taxpayers. He was re-elected in 1962, 1964 and 1966.

Schweiker ran for the Senate in 1968 and defeated incumbent Joseph S. Clark. He was re-elected in 1974. In addition to his service on the Labor and Human Resources Committee and the Appropriations Committee, Schweiker served on the Senate Armed Services Committee, the Senate Rules Committee, Joint Economic Committee, Select Committee on Intelligence Activities, Select Committee on Nutrition and Human Needs, and the Technology Assessment Board.

He was selected by President Reagan to be his running mate in the 1976 GOP presidential campaign. In the 1980 race he served as President Reagan's northeast states campaign chairman.

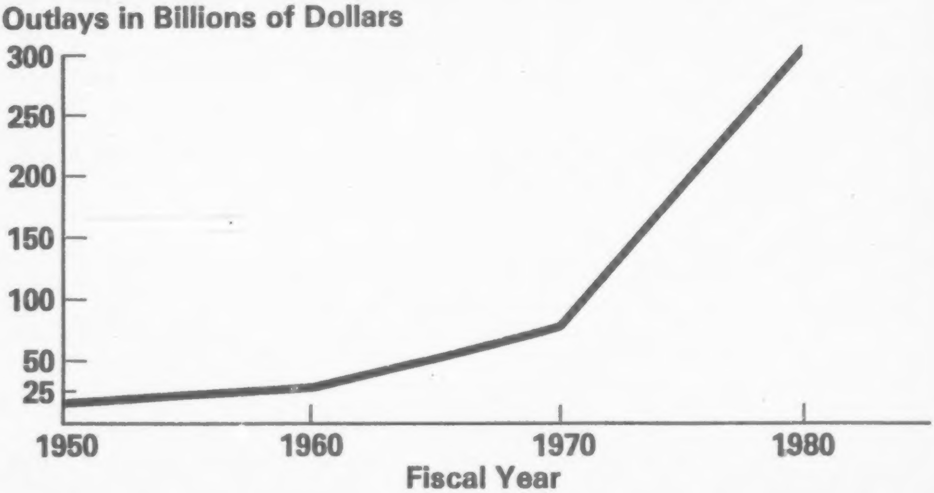
Schweiker has received seven honorary doctoral degrees. Among other honors he has received are: National Association for Mental Health Award (1974); Opportunities Industrialization Centers Key Award (1974, 1977); OIC's Legislative Pathfinder Award (1980); National Society for the Prevention of Blindness Award (1974); Council of Jewish Federations Distinguished Service Award (1978); Pennsylvania Pro-Life Convention Award (1978); the National Association of Independent Colleges and Universities Distinguished Service Award (1980); Dr. Charles H. Best Award, American Diabetes Association (1974); Humanitarian Award, Juvenile Diabetes Foundation (1974, 1977); Juvenile Diabetes Foundation "Man of the Year" Award (1980); PA/Conservative Union "Appreciation Award" (1978); Distinguished Alumnus Award, Pennsylvania State University (1970); Volunteers of America Booth Award (1980); and Honorary Member, Slumbering Groundhog Lodge, Quarryville, Pa. (1970).

January 1981

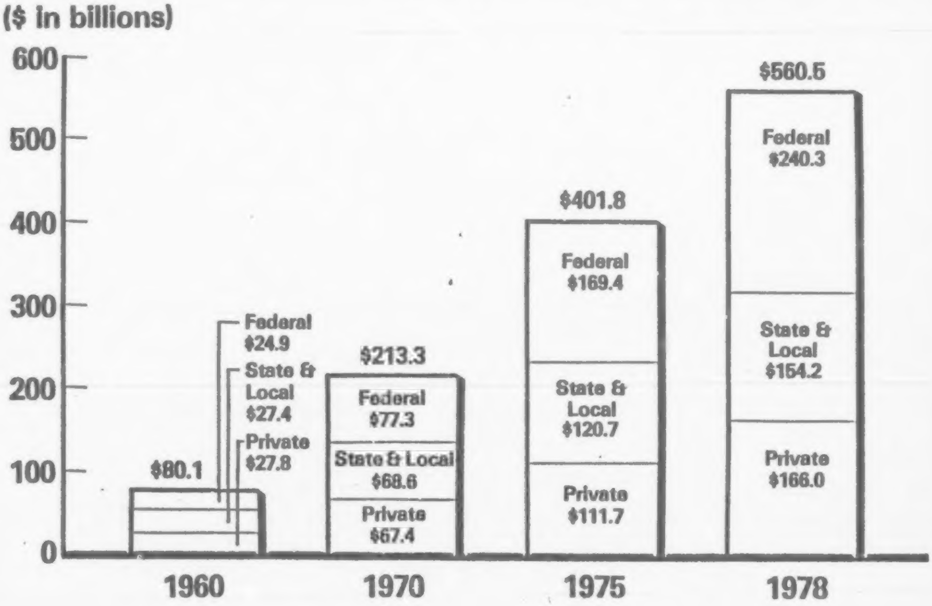
Growth in All Federal Social Programs

(Outlays in Billions of Dollars)

(Includes Programs in HHS, Labor, VA, Education, Agriculture, HUD, and Other Domestic Agencies)

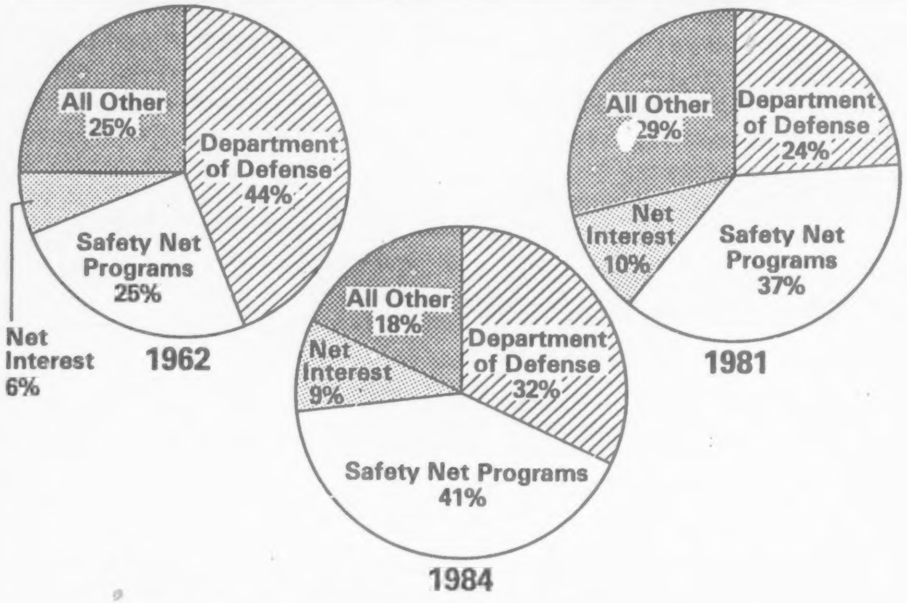


Public and Private Expenditure for Social Welfare



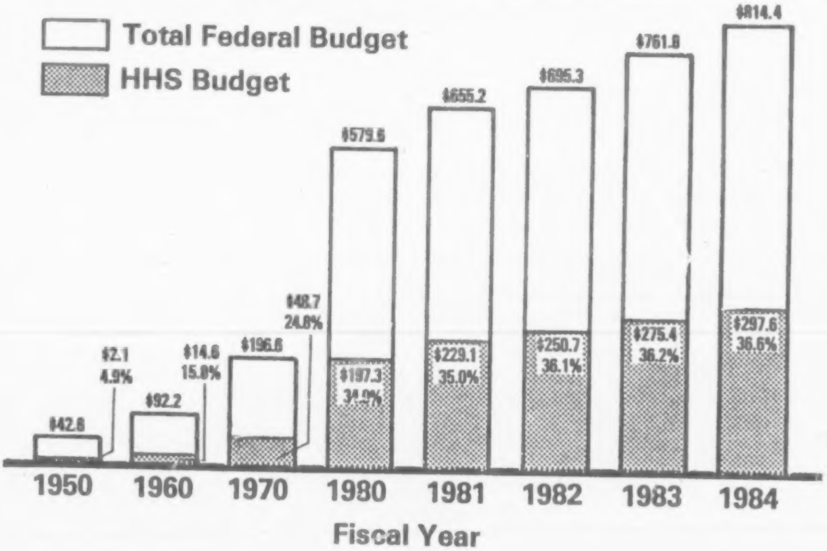
Shift in Budget Priorities

(Percent Composition of Outlays)



HHS Percentage of Federal Budget

Outlays in Billions of Dollars



FY 1982 HHS Budget Changes

All Other Departments Excluding HHS and Defense Were Reduced 13.4% but the HHS Budget Was Reduced 3.5% from the Carter Budget.

With 36% of the Federal Budget, HHS Share of Reductions Was Only 20.5%.

Increase in HHS Budget from FY81 to FY82 Equals $21.5 Billion — 54% of Increase in Total Federal Outlays.

The Cost of Inflation to HHS Programs

A One Percent Increase in Inflation Increases the Cost of:

Medicare	$ 500,000,000
Old Age, Survivors and Disability Insurance	1,400,000,000
Supplemental Security Income	50,000,000
Total	$ 1,950,000,000

The 1981 Medicare Inflation Adjustment and Social Security Cost of Living Adjustment Will Increase the 1982 Costs of These Programs By:

Medicare	$ 5,043,000,000
Old Age, Survivors and Disability Insurance	14,900,000,000
Supplemental Security Income	560,000,000
Total	$20,503,000,000

Block Grant Benefits

- **Improves Services Delivery Effectiveness:**
  - Assigns Responsibility to States
  - Provides States with Resource Control and Flexibility
- **Allows States to Meet Particular Needs and Priorities of Their Citizens**
- **Makes More Efficient Use of Resources:**
  - Eliminates Duplicative Administrative Overhead
  - Removes Unnecessary Federal Requirements

Health Service Block Grant

Consolidates 15 Programs:

- Community Health Centers
  - Primary Health Care Centers
  - Black Lung Clinics
  - Primary Health Care
- Migrant Health
- Home Health Services
- Maternal and Child Health
  - Grants to States
  - SSI Payments to Disabled Children
- Hemophilia
- Sudden Infant Death Syndrome
- Emergency Medical Services
- Mental Health and Substance Abuse Services
  - Mental Health Services
  - Drug Abuse Project Grants and Contracts
  - Drug Abuse Formula Grants to States
  - Alcoholism Project Grants and Contracts
  - Alcoholism Formula Grants to States

Appropriation Authorization: $1,138 Million

Preventive Health Service Block Grant

- **Consolidates 10 Programs:**
  - High Blood Pressure Control
  - Health Incentive Grants
  - Risk Reduction and Health Education
  - Venereal Disease
  - Fluoridation
  - Rat Control
  - Lead-Based Paint Poisoning Prevention
  - Genetic Disease
  - Family Planning Services
  - Adolescent Health Services

Appropriation Authorization: $242 Million

Energy and Emergency Assistance Block Grant

- **Consolidates Two Major Programs:**
  - Emergency Assistance Under the Social Security Act – both HHS and CSA Components
  - Low-Income Energy Assistance

- **Funds Can Be Provided for:**
  - Home Energy Costs
  - Low-Cost Weatherization
  - Temporary Financial Assistance, Food, Clothing, Shelter
  - Emergency Medical Care
  - Emergency Social Services

Appropriation Authorization: $1.4 Billion

Social Services Block Grant

Consolidates 12 Programs:

- Social Services
- Day Care
- State and Local Training
- Child Welfare Services
- Child Welfare Training
- Foster Care
- Child Abuse Prevention and Treatment
- Adoption Assistance
- Developmental Disabilities
- Runaway and Homeless Youth
- Community Services Administration (economic development not included)
- Rehabilitation Services

Appropriation Authorization: $3.8 Billion

BUDGET REQUEST

Secretary SCHWEIKER. Mr. Chairman and members of the committee, I'm pleased to be here today to discuss the fiscal year 1982 budget for the Department of Health and Human Services.

This budget is an essential part of the President's program for economic recovery and reflects three principal goals of this administration: First, to maintain our Nation's commitment to protecting and serving those most in need; second, to slow the growth of Federal spending by targeting the resources we have on our most pressing domestic priorities while reducing waste and abuse; and third, to restore the States and their local governments to full and effective partnership in the Federal system.

Our budget proposals make good on the President's promise to protect essential social programs while reducing growth in Government spending and limiting the influence of Government in our economy and in our daily lives.

For this program to succeed, budget control is essential. You know and I know that the most valuable thing we can do for most people is to assure an economic environment in which they can get jobs to take care of their families and themselves and to assure that their pay checks grow in value as a result of increased productivity and lower inflation.

INCREASES IN SPENDING

Mr. Chairman, I would like you to look at this chart for a minute. I think if there is any one chart that shows the problem clearly and graphically of the whole country, the economy, inflation, and my Department, this one chart is it. This is a graph of the different social spending programs the Government has provided over the last 30 years.

It includes Health and Human Services Department programs, Labor Department programs such as job training and CETA, VA payments, education programs such as college loans and student assistance, Agriculture Department programs in terms of food stamps, and HUD programs in terms of rent subsidies. These are the total expenditures in social welfare programs.

An interesting fact is that back in 1950, we were spending under $20 billion. Today these programs have grown like a rocket, up to $300 billion. In the 1950's, there was a fairly gradual increase. It went up something like 82 percent in the decade of the 1950's in social spending.

In the decade of the 1960's, it went up about 188 percent, not quite doubling in its escalation, but in the 1970's it took off like a rocket. It went up 313 percent. As you can see, the line begins almost to approach a vertical takeoff. This, in essence, is our problem. We have got to slow that growth line. If there's any one thing we have to do and that is what the Reagan administration is setting out to do, it is to change that line of spending to a more gradual slope from the vertical position where it now is.

Along with the spending of the Federal Government, there has been a tremendous influx of State spending and private spending on social problems. I think it is important to note this when we talk about cutbacks in the Federal sector. This basically is spending on social welfare.

I've already shown Federal spending on the other graph; the Federal spending went up from $24.9 billion in 1960 to $240 billion in 1978, an 18-year period. That is about a tenfold increase. State and local spending for social welfare went up six times to $164 billion; and private spending—private groups, foundations, charity drives—went up six times. So in that 18-year period, we've increased spending sixfold in the private sector and tenfold in the Federal sector. When we're talking in the Reagan budget about cutting $48 billion, you are really cutting less than about 7 or 8 percent of our total money spent on social welfare. That is quite a bit different from the picture that some of the headlines give us today. We have a $48 billion cut. It isn't all in the social welfare sector; but even if it was, it is less than 10 percent of that bar graph.

What happens to defense spending? The argument is that we are robbing the people's programs to put it in defense. Not true. Not true at all.

SOCIAL SAFETY NET PROGRAMS

I think the myth of that argument is pretty well shown here. In fact, when I was a Member of Congress in 1962, we were putting 44 percent of total Federal spending into defense. This was under John Kennedy's tenure. In these safety net program—we haven't used all the social programs, just the safety net—we were spending about 25 percent in 1962. These figures have somewhat reversed themselves in 1981. Defense is way down—20 whole percentage points—down to 24 percent of the budget. The safety net programs are up to 37 percent of the budget—not quite a reversal but almost. This is a big percentage decrease in defense spending.

Even with this budget cut that we're proposing in 1982 and the ensuing ramifications, the safety net programs will still increase to 41 percent of the budget by 1984. Defense will increase but will still be way behind, with 32 percent of the budget. So this talk of robbing the people to pay for defense just is not true. Defense will only rise to 32 percent of the budget in 1984. Defense spending was at 44 percent of the budget under Kennedy. We are nowhere near that percentage. So the budget should be put in that perspective.

Now looking at my Department, you'll see a somewhat similar story. Back in 1960, the Department's budget was about 15.8 percent of the budget. Today it's 35 to 36 percent. Even with the cuts, it will edge up to 36.6 percent of the total budget by 1984. Our program share will not decrease, even with all these cuts. Again, you don't get that feeling and that perception from what the media has said.

I think there are a few statistics that dramatize the same points about the cuts that we are making. If you take the reductions in the entire budget excluding Defense—obviously they are getting preference—and our Department, the other Departments are getting a 13.4-percent cut from the Carter budget. Our reductions are only 3.5 percent from the Carter budget. So proportionately they're getting a 13.4-percent reduction— all the other Departments except Defense. We are getting a 3.5-percent reduction in our total $250 billion budget.

As you know, our budget is larger than any country's budget in the world except for the Soviet Union, and the entire U.S. budget. It is the third largest government entity in the world. Another way of looking at it is that we are 36 percent of the Federal budget, and we are only being asked to take 20 percent of the cuts. So the decrease from the Carter budget amounts to 20 percent of the total budget cut, even though we are getting 36 percent of the Federal budget in the fiscal year coming up.

Another way of looking at it is that our budget is not being cut. I think that is important to say that our budget is being cut only relative to the Carter budget. But in terms of actual spending, compared to last year, we are increasing the HHS budget by some $21.5 billion, even with the 9 billion dollars' worth of reductions from the Carter budget. So with an increase of $21.5 billion, my Department will get 54 percent of all the increases in the total budget. In fact, we're getting the lion's share of the increased spending. I think it's very important to put all these facts in perspective when we look at the other programs.

INFLATION

One of the real culprits of increased spending is inflation. If you look at this whole chart, inflation is a big factor. The reason the President's program seeks to control Federal spending is to get a grip on inflation, so that we don't see inflation forcing spending for these programs off the chart.

For example, because many of our Department's programs are indexed to inflation, a 1-percent increase in inflation means a $500 million increase in medicare, a $1.5 billion increase in old age and survivors and disability insurance, and a $50 million increase in SSI. So every time inflation goes up 1 percent, I've got to spend $2 billion more in my Department just to stay even, just to give the same real benefits we are giving now.

What does that mean in fiscal year 1982? Under the projected inflation rate for 1982 those same three items, medicare, social security, and SSI, will cost us an additional $20 billion in 1982 just to give the same real benefits that are being given in 1981. In essence, inflation is the culprit. The inflation spiral is what we're trying to get our grips on. That affects my Department because of medicare, OASDI, and SSI.

Senator SCHMITT. Mr. Secretary, is it safe to say a 1-percent decrease has the opposite effect, 1 to 1?

Secretary SCHWEIKER. Yes, in some cases.

Senator SCHMITT. There's nothing built in that holds it up, even with the decrease in inflation?

Secretary SCHWEIKER. That would not be true in the case of medicare because of the base. The other programs probably would be affected.

Senator SCHMITT. Could you expand on that for our record please?

Secretary SCHWEIKER. There is a difference in several programs. I guess the answer to your question would be that if there was not a 1-percent growth in these programs, we would not have to spend all of that money. We would have to spend some of it.

COMMENSURATE BUDGET SAVINGS

Senator SCHMITT. What I'm trying to get at, if next year as a result of the President's program or other factors, we see an actual 1-percent decrease in the inflation rate, do we then get a commensurate savings in the budget?

Secretary SCHWEIKER. You get the savings in the sense that you won't have to spend that additional amount of money. We wouldn't reduce benefits in the program. I think you have to look at it in two ways: Because of the indexing feature, you wouldn't be taking money out of people's paychecks; but by the same token, you wouldn't have to spend the additional money for benefits. So there is not a direct relationship. What happens depends on the program, and we obviously don't take benefits away from people.

Now although State and local expenditures on social welfare programs have also grown remarkably since 1960, Federal spending has outpaced that rate of growth. State and local and private spending has increased roughly six times, while Federal spending has increased tenfold.

The President's budget seeks to restrain this growth while protecting the most needy. Safety net programs in all Departments now constitute 37 percent of total Federal outlays, whereas outlays for the Department of Defense constitute 24 percent. Projecting to 1984, we see that both national defense and the safety net programs are increased. One does not increase at the expense of the other.

I believe this perspective on the budget is important. Our programs are there when there is nowhere else for the elderly, the disabled, the poor and the sick to turn. And our social insurance programs are there to provide basic income and medical protection for workers and their families at retirement, in the event of death and disability. These programs will continue to be a growing proportion of the budget, rising from 34 percent in 1980 to 36.6 percent in 1982.

Our budget was not reduced disproportionately relative to our basic mission in other areas. Our outlays are down 3.5 percent from the January Carter budget, compared to outlay reductions of 13.4 percent for all other Departments, excluding Defense. Our share of the reductions from the January budget was 20.5 percent.

Finally our spending growth accounts for 54 percent of the increase in total Federal outlays for fiscal year 1981 to 1982. The budget I present today reflects the significant policy changes needed to achieve the administration's goals.

As you well know, the Federal budget both drives and is driven by inflation. Nowhere is this more significant than in the safety net programs, most of which are indexed directly or indirectly to the cost of living. Indeed, for social security, SSI, and medicare, each 1-percent increase in the CPI costs nearly $2 billion. The full-year cost in 1981 of the July 1981 social security cost-of-living increase alone will be $14.9 billion.

I recognize that indexing is a controversial subject at this time. But this administration has made the judgment that it will protect fully the real value of benefits as it seeks through other measures to bring the rate of inflation under control.

These other measures include reform of entitlement programs to eliminate unintended benefits and to avoid unnecessary costs. We must reevaluate across the board whether the Federal Government should try to be all things to all people. Since we do not have the financial ability to do so, what has evolved is a fragmented, inequitable system in which the distribution of benefits seems to have lost its sense of logic.

Can we sustain a situation in which one out of three households receives one or more public noncash benefits, as recently discovered by the Census Bureau? I'm sure you saw the report in the paper.

We are proposing legislation to limit unconstrained growth in the medicaid program, to assure that the aid to families with dependent children program is available only to the most needy, to eliminate certain secondary social security benefits such as adult students' benefits and the minimum benefit, and to tighten eligibility for disability insurance. In all, savings from proposed legislation affecting entitlement programs and the child support enforcement program total $5.8 billion in 1982.

I should also note that the Department has a corresponding program to curb excess costs and reduce program misuses and waste through management reforms. Our very preliminary targets are for management savings of $2.1 billion in 1981 and $3.1 billion in 1982, based on current law.

Obviously when our legislative and budget proposals are enacted, we will have to revise our management savings estimates to reflect the fact that savings have been achieved legislatively, but we will continue our comprehensive analysis of potential management savings areas to try to make up for any shortfalls that result. One of my first directives at the Department instructed office heads to intensify their efforts in this regard.

Another major element of this budget is the consolidation of categorical programs into block grants.

The budget proposes consolidating 40 categorical health and social service programs into four block grants: Health services, preventive health services, social services, and energy and emergency assistance.

1982 FUNDING LEVEL

The proposed 1982 funding level is set at 75 percent of 1981 current services. States will have complete flexibility with respect to its use. Moreover, as noted by the GAO in its March 3 document commenting on the President's February 18 budget proposals, grant consolidation should have another even more positive aspect for State and local governments. The GAO points out that proliferation of narrow categorical programs has, in subtle and in not so subtle ways, warped and twisted State and local program priorities as they seek to maximize Federal matching.

Simply put, they may decide to put 40 cents of their money into a program of secondary priority in order to attract 60 cents from the Federal Government, rather than putting their 40 cents into a nonfederally matched program that would better fit local needs. Thus the GAO concludes that, and I quote, "Federal grants available for a broader range of purposes would increase State and local discretion and move toward supporting rather than changing State and local priorities."

The block grants also will result in a significant reduction in administrative costs. Nearly 2,440 fewer Federal staff-years will be required compared to the operation of categorical programs—2,440 fewer people to write burdensome regulations, to mandate detailed reports from State and local governments, and to analyze and propose new programmatic wrinkles.

As I indicated, we are proposing four block grants: Health services, preventive health services, energy and emergency assistance, and social services.

You will note that the chart for preventive health services reflects a decision of a few days ago within the administration to exclude immunization and leave it as a categorical Federal program.

PUBLIC HEALTH HOSPITALS CLOSURE

Beyond the block grants and legislative savings, every program in the Department has been subject to intense scrutiny and reconsideration, given the overall fiscal situation and the need to reassess what responsibilities properly fall within the purview of the Federal Government.

The major reductions resulting from this scrutiny include the closure of the Public Health Service hospitals and termination of free Government health care for merchant seamen; the phaseout of the health planning and professional standards review organization programs; the phaseout of grants and new loans for health maintenance organizations by the end of 1983; and the streamlining of support for health professions training.

In total, in addition to the program dollars saved, these and other program reductions and terminations would result in a decrease from the 1981 level of about 8,700 full-time permanent positions and their associated overhead.

Mr. Chairman, to maintain basic protection for our citizens, we must be more selective in what we attempt. Our legislative savings package is an important element in achieving this selectivity. We must also give

State and local governments greater flexibility in operating programs that follow their priorities and meet the needs of their citizens, rather than our perceptions of those needs. Our block grant proposals are essential in this regard.

I look forward to working with you and your committee to achieve these goals.

Thank you, Mr. Chairman.

Senator SCHMITT. Thank you, Mr. Secretary.

Obviously there is a great deal of emphasis in your budget proposals on the block grant concept. An assumption, I take it, that the concept will be approved by the Congress.

Secretary SCHWEIKER. I am sorry, Mr. Chairman. I didn't hear all that.

Senator SCHMITT. You have placed a great deal of emphasis in your testimony and in your activities on the block grant proposal. Am I correct in assuming that the budget reflects the assumption that those block grant proposals will be approved by the Congress for fiscal year 1982?

Secretary SCHWEIKER. That is the budgetary assumption; yes.

Senator SCHMITT. Have you carried that assumption back into the rescission?

Secretary SCHWEIKER. Mr. Chairman, in programs that have a direct relationship we have; in some programs we have not. So the answer is where there was a direct tie-in linkage between one and the other, to some extent we have.

MENTAL HEALTH PROGRAMS

Senator SCHMITT. Can you give a specific example so we can better understand that? For example, in the one that you discussed here.

Secretary SCHWEIKER. One example is the mental health program. We have a rescission pending for no new awards to the States in 1981 since they will be handling mental health programs in a block grant program the following year. We have rescissions reflecting the fact we are moving programs into block grants in 1982. That would be a typical illustration.

Senator SCHMITT. Now have you tried to deal with the fact that some States' legislative period is less than full time, and some like my home State of New Mexico are actually out of session now and will not come into session again until early next year?

Secretary SCHWEIKER. Mr. Chairman, we are going to have to be realistic on this. Keep in mind for many of these budget proposals the deadline is October 1. You are quite right that some legislatures will have to respond in specific ways. There may be some extenuating circumstances that we will have to take into account in the process. Some States will be able to respond in a meaningful way and some will not.

I think, for example, a number of States will have bases from which to operate, regardless of new legislation. Under the health services block grant, States could use their maternal and child health groups and the drug abuse and alcohol agencies as instruments to work within this block. They might be well able to put just a few people in these organizations to oversee some of the administrative aspects of the block grant.

Under preventive health services, the States could use their present State health departments which already administer programs which will be within the block grant, such as the health incentive grants and the venereal disease programs. Under the social services block grant, States already have title XX. Title XX is a block grant that is big and already in place. The States could use their existing title XX grant and expand that, because that's the lion's share of that particular block grant.

We believe States could utilize their own agencies which are already using Federal money for those programs. There still may be some problems, and we are certainly willing to try to accommodate them.

EDUCATION PROGRAMS

Senator SCHMITT. This is no longer in your department, but I heard the other day that in anticipation of blocks in the education programs teachers were being laid off rather than looking at the administrative overhead that presumably would be saved. Do you see that happening yet in your programs or do you anticipate it would happen? Is there any way that you could safeguard the providers from being the ones that are laid off by administrators, who are really the ones we have been trying to get at?

Secretary SCHWEIKER. It depends on which category or program you are talking about. But basically, there are staff positions that would be in these categorical programs. We have put money in the budget proposal for whatever reductions in force would be required, but we haven't yet laid anybody off.

Senator SCHMITT. I am talking about at the State level. You are depending on the States now to move more efficiently, as a result of the block grant program, and I agree with that theory. However, the practice apparently on the education side, at least in one instance that I have been told about, is to lay off teachers rather than administrators and counselors that have been part of the categorical program.

Secretary SCHWEIKER. Mr. Chairman, I am not aware of any of that happening as yet.

Senator SCHMITT. Do you agree that it is a possibility at the State level that that may happen?

Secretary SCHWEIKER. I would hope not. As a matter of fact there are two things that I think have to be said here that maybe haven't been clear from some of the discussions in the press.

For example, Governor Bond of Missouri has a director of health who was quoted in the Washington Post as saying, "One in five of his employees works to comply with the Federal regulations of the more than 40 health programs funded by Washington." And he predicted that his office would do a better job with 75 percent of the funds it now gets from Washington if the Federal mandates were eliminated. To have seed money, to have a push from Washington, that's great, he said; but once a program is institutionalized it is not cost effective to run it from Washington, where they don't know the difference between St. Louis and Boot Hill.

My point is, there are responsible State administrators who feel they can save a lot of that money just because they won't have to prepare detailed, comprehensive Federal plans and reports; they will not have an enforcement arm to deal with; they won't have to supply the extra paperwork and deal with the bureaucracy that we have imposed.

There is another one of our proposals that is important, and this has not been emphasized. Our proposed changes in the eligibility requirements for some of the welfare programs, AFDC, for example, will save the Federal Government $1 billion. The States will also save an additional $850 million; they will not be required to spend $850 million of their present tax resources.

Under the block grant programs that we have proposed, the States may have $850 million that they won't be obligated to spend compared to what they are spending now. They will have the option to do whatever they want to do with that. They can put it into some of their high-priority programs. They can put it wherever the need is greatest. But because we are relieving them of as much as $1 billion of their present burden, they will have some resources to respond in a very meaningful way.

OVERHEAD REDUCTION

Senator SCHMITT. But don't you agree that at the State level there may be some difficulty in getting the administrative overhead reduced rather than the provider base reduced? And you are saying that, if there is a difficulty, that is something that needs to be solved at the local level, that you don't see any way in which the Federal Government——

Secretary SCHWEIKER. What I am saying is that the States will have another $1 billion available to solve those problems. So I cannot believe that they will be in a straitjacket, because we are mandating—if our budget proposals are approved for medicaid and AFDC, we would be mandating $1 billion less expenditures for the States under the matching formulas for these programs. So they will have $1 billion freed up, which I think would be significant to meet these problems.

I am not disagreeing with your point.

Senator SCHMITT. I understand that. But you would agree the States must be very cognizant of the pressure that is going to come, that may come for administrators to get rid of provider base rather than the administrative overhead.

Secretary SCHWEIKER. Right.

Senator SCHMITT. The provider base tends not to have as good a lobby within the administration as do the administrators.

Secretary SCHWEIKER. In response to that, Mr. Chairman, we did consider putting an administrative limit on expenditures to deal with the very problem you are talking about. We did consider that. We finally decided not to make that proposal because with 40—39 programs it becomes very complex to say what a fair limit is or what it should be, but we finally decided not to include that. But that was under consideration.

Senator SCHMITT. Could you provide us with at least a discussion of that alternative, so that we can have the benefit of your thinking on it?

Secretary SCHWEIKER. Sure.

Senator SCHMITT. For the record.

Secretary SCHWEIKER. OK.

[The information follows:]

We rejected imposing administrative cost limits for several reasons.

First, as a practical matter, it would be extremely difficult to devise such a limit. Administrative costs vary widely among the existing programs, partly because of real differences in the administrative complexities of different services (e.g., day care vs. health care services billable to third parties). Moreover, in many programs the duties of field staff such as nurses and social workers, are partly administrative and partly services delivery, so that a strict accounting and enforcement would be very difficult and expensive to administer.

In addition, we do not have a clear baseline. Existing data on administrative costs differ from program to program in both accuracy and concept. There is no way to reconcile the data—the very categorical system we propose to replace has precluded uniformity.

Finally, it is not always which costs are administrative and which are not—are advocacy activities, caseworker followup, keeping of patient records by doctors, receptionists, and a host of other activities administrative overhead or actual services?

Second, the block grant proposals provide States flexibility to shift funds among services, services which differ in appropriate level of administrative costs. A fair limit would have to be service-weighted to avoid restricting the States, or else set so high as to be meaningless. Indeed, the States could probably avoid a limit simply by funding administrative costs from own funds.

Third, we do not believe there is a need for such limits. We consider that the States—being clearly responsible for the principal decisions on priorities and funding levels among services—will be under strong pressure from their own citizens to hold down administrative costs.

In sum., establishing such a limit would have been cosmetically attractive, but may have been burdensome, and would have been of doubtful effectiveness, at best. Absent any compelling Federal interest in attempting to dictate State administrative accounting practices and costs, and in view of the complexities, we decided not to propose such a limit.

BLOCK GRANTS

Secretary SCHWEIKER. One other thing is that under 314(d) the States have had more than 10 years experience in dealing with a block grant program for basic public health services. So just as you have a prototype in social security of title XX, where a number of programs are now consolidated, you also have a prototype in 314(d).

So each State does have an agency; they have a program; and they have administrative personnel with some 10 years experience in these areas to use as a base.

Senator SCHMITT. There has been some concern with the block-grant proposal under the health service block grant, that there is different levels of sophistication in the existing infrastructures that supports each one of those categorical programs within the State. When these programs are blocked, the political powers of the different programs within the State are not equal. Community health centers may not have as strong an infrastructure as, say, the mental health and substance abuse services. I don't know that that is true. But it would be—I think it is safe to assume that that infrastructure would vary from program to program.

Again you would argue, I presume, that the State must assume the responsibility for evening-out the distribution of resources, depending on what its specific State needs are and its local needs are.

Secretary SCHWEIKER. Mr. Chairman, I hate to bring up a law of physics here since I know the chairman is a distinguished physicist, but I believe that the law of physics that applies to this situation is that objects in motion tend to remain in motion. I have to believe it is not as though we are starting 40 new programs from scratch. I think if we were starting 40 new programs from scratch, I would completely agree with the criticism that has been raised. But in all these areas where there is an ongoing funding operation, there are people there. There are people getting salaries there, people getting services there. I have to believe, knowing how Washington works, that the same people who have pushed for funding these programs, will just go to their State capital to do the same.

If we didn't have the base, if we didn't have the ongoing programs, now the law of physics wouldn't be applicable. Then I would be a little more concerned. But I think that consumers of the programs will be heard.

Under our proposals, I might say, each State does have to publish in advance where it intends to spend the money within that block grant in order to give State legislators and the people time to comment and respond.

I believe the system will work in the States somewhat the way it works here, but this is one of the questions that has been raised.

Senator SCHMITT. OK. Through what formula or mechanism will the block grants be allotted to the States?

Secretary SCHWEIKER. We had some detailed discussion on this, but we decided that using the status quo would be the fairest mechanism. There are alternative methods of computation for a State's allotment. One is that if there is a State formulation in the present legislation, we would use that State formulation. Whatever the State formulation for the program is, that will be exactly followed in our bill.

In addition——

Senator SCHMITT. But that is different for different components that are going to be subject to block grants.

Secretary SCHWEIKER. That's right. The dollars will all be added. In other words, if a State gets 6 percent of the dollars for a specific program, then that 6-percent dollar figure will be added to that State's credit. For the next program, if the State gets 3 percent of the dollars, that 3 percent of the dollars will be added to its credit. We will combine credits from all of the 40 programs for each State.

There is one other basic alternative, and that is that in addition to the State formulation, where there is no State formulation, then we will add up the actual grant expenditures for fiscal year 1981. So we will do it either one of two ways: Either total what was actually spent in fiscal 1981, or, if there is a State formulation, follow the State formulation. The total dollars will then be credited to each State and that will be the State's pro rata share for that block grant, reduced by 25 percent.

If the Congress wants to change the formula, we are perfectly willing to consider that. But having been through so many of those formula grant fights, I just didn't see how we could rewrite 40 formulas——

DISTRIBUTION OF STATE RESOURCES

Senator SCHMITT. I take it, those fights have been relative to each program? Let's assume the formulas can be integrated and still exist as guidance to the States on how they distribute those resources.

Secretary SCHWEIKER. We will use the latest census data so that the population figures aren't 10 years behind, to be fair.

Senator SCHMITT. Are there any programs to which you would give special treatment and protect over transition period in the block grant program?

Secretary SCHWEIKER. Let me say that there are some programs that have a national focus, and we are trying to exclude those with a national focus. For example, in the block grant program, we have a runaway youth program.

If I may illustrate how we are handling that, I think the same principle applies to our health programs. In the runaway youth program, the activity occurs at the State level, and that is where the block grant money will go. But the runaway youth hotline, is a national program; therefore, we have a way of consolidating the hotline into our proposal.

There are approximately six categories for social research grants. And we are consolidating them into a Federal block so that we will have the right to spend Federal money for those social research programs. We can fund, for example, research on that runaway youth hotline and keep a national focus.

To some extent, we have done that in ADAMHA and other programs, where if the activity is handled best at the State level in block grants, we leave it to the States; but where there is a national focus, we keep the program at a Federal level.

IMMUNIZATION PROGRAM

Senator SCHMITT. That's very helpful. I detect that generally you have looked at the programs, health programs, for example, and where they relate solely to local effects, even though you may find the same local effects in New York that you find in New Mexico, nevertheless it is a local effect that is causing the problem. You have said that can be blocked.

But where there is a cumulative effect that can cross State lines, then you have tended not to block that. And I suspect that that's the reason that the immunization program was left out of the blocks. However, when I look at venereal disease, for example, we have had testimony previous to your appearance today that pretty strongly reported the interstate nature of the disease. Now, could you tell us, for example, why venereal disease was included in the block, and the other programs were not?

Secretary SCHWEIKER. The answer is that the immunization program deals with prevention and occurs before the fact; whereas venereal disease involves treatment after the disease occurs. We had originally included the immunization in a block grant. However, we decided that immunization program was a critical program: If you didn't treat children to develop an immunity, then there are health consequences, no matter where this occurs.

So we made a request to OMB for a maintenance-of-effort program that would continue the States present level of participation in this program. The OMB decided that a maintenance-of-effort requirement was contrary to block grant program principles.

Therefore, we resolved the issue by taking the immunization program out of the block grant and leaving it as a categorical program.

But we do see a difference between treatment as opposed to immunization.

VENEREAL DISEASE TREATMENT

Senator SCHMITT. Well, I understand, but still, within venereal disease, for example, in contrast to fluoridation, the treatment requires or can be affected by what's going on outside a State—whereas fluoridization would not.

Secretary SCHWEIKER. Part of the answer is that there is a national component that will continue. Research at NIH on venereal disease will continue and CDC will continue its in-house capacity for controlling venereal diseases. CDC's program will include establishing clinical standards for VD testing, laboratory diagnosis, and developing new, more cost-effective diagnostic and prevention methods for special VD control problems—such as drug-resistant gonorrhea strains and pelvic inflammatory diseases.

So we will continue our national CDC program on control of venereal disease.

Senator SCHMITT. So if a vaccine appeared that could be universally applied to some venereal disease on an economical basis, cost-effective basis, that would fall into a different program than the block grant?

Secretary SCHWEIKER. It certainly would, and let me say I know how serious this problem is. If such a vaccine was developed I would certainly say that use of the vaccine was a national program, and should be initiated by CDC.

Senator SCHMITT. Senator Rudman?

LOW-INCOME ENERGY ASSISTANCE

Senator RUDMAN. Thank you, Mr. Chairman.

Mr. Secretary, I want to talk about one specific program in some detail. I would like to have an opportunity to dissect that program with you this morning, to dissect it in light of the statements of the administration, which I concur with completely: That no one who is in need in this country is going to suffer with these program cuts that have been proposed by the President's budget. I share that view. I am sure you do.

I think it comes down to a question of what is need. And I define "need" this way, so you'll know exactly the supposition on which I proceed from: If we're talking about people eating, people keeping healthy, with adequate medical care, in the case of the northeast people freezing, that's need.

And if these programs don't work, if we conceived them improperly, it's my belief that we will have great difficulty in keeping the constituency of this country behind our programs.

With that background, I want to discuss the low income energy assistance which, in the State of New Hampshire and in many other States in this Nation, is very critically defined as need.

Now, let me tell you my understanding of it, so at least we're proceeding from the same facts. The low-income energy assistance program presently is a $1.85 billion formula grant program. Money is distributed to the States and then distributed by the States in accord with a plan and a formula approved by HHS. To a large extent, I think you could define the program as a block grant program.

Now, the proposal of the administration is to combine this program with another $50 million program, a small program referred to as social security emergency assistance. They're going to rename this block grant the energy and emergency assistance block grant.

As I understand it, from looking at the administration's proposal and information provided by OMB, funds are going to be available for home energy assistance, other temporary financial assistance—weatherization, emergency medical care. It's going to be funded at a $1.4 billion level, or 26 percent below the combined total funding for the two programs, and about 24 percent below the amount we're now spending just on low-income energy assistance fund.

Interestingly enough, 97.4 percent of what's going into the block grant is low-income energy assistance.

I have got three questions. No. 1, I want to know what the rationale is for a 25-percent cut in the funds available for this block grant when essentially it's already a block grant, I think, administered with a fairly low level of administrative costs.

So I have to challenge that presumption, that a substantial reduction in fact will be realized through administrative savings. I think that's easier said, in this case, than done.

Second—and I think this is most important—with deregulation of oil, which, as a New England Senator, I supported, and with the huge amount of money coming into the Federal Treasury through the windfall profit tax, money not available to the States in any taxing method of their own, and with fuel oil prices in New Hampshire now going up through the roof, and with literally 17,000 families dependent on this, people of low incomes, people who are elderly, people who are poor—I want to tell you, Mr. Secretary, that I think that the people of New Hampshire this past winter, many older people, made clear choices between heating and eating, and if that's not need, I don't know what is.

I want you to justify the administration's position in this program, knowing, Mr. Secretary, that I support the administration, that I voted with the administration, that I believe in your program, but I think you made a mistake in this particular area.

ENERGY BLOCK GRANT

Secretary SCHWEIKER. Thank you, Senator. First, let me explain one or two things. Initially, when this proposal came to me from OMB, the proposal was to place all 40 categorical programs into one block grant, including energy. So, unlike the situation you see in here in the chart, the low-income energy program would have been merged with 39 other programs. I successfully argued that energy had a high priority, that it was one of the most important programs.

If you look at these four charts, you will find that it received the most preferred treatment of any program, because we singled it out in terms of its treatment. It is almost a categorical program in that we put in a separate block grant with only two components. The other component is a very small program.

In essence, we gave the low-income energy program categorical standing. I won that argument with OMB because of the priority we place on that program.

Second, we do give States the right to transfer 10 percent of the money from one block grant to another. If low-income energy was the highest priority in that State, the State could take 10 percent from its social services block grant, 10 percent from its preventive health block grant, and 10 percent from its health service block grant, and put it in the energy and emergency assistance block grant, which would be a 30-percent add-on—if that was the need and desire.

Second is—I mentioned this a moment ago and I think it's worth repeating—the reconciliation package that we are proposing relieves the States of some mandates that we had required previously in the welfare area, and in relieving the mandates in the welfare area, the Federal Government will save about $1 billion a year, and the State governments will save another $850 million a year.

So what I am saying is this package will also free the States of $850 million in current spending in the welfare area that we had previously mandated by a 50–50 matching requirement. So the States will have an extra $850 million to spend that they don't have now, because we're wiping out the requirement.

Now the States will have new money available for this purpose.

I can't argue about the priority of the low-income energy program. I agree that's why it is a single categorical program in this block grant. I can't argue about the cost of home heating oil going up. That's why we provided the flexibility. So I really don't argue with your basic position.

COST OF HOME HEATING

Senator RUDMAN. Well, let me follow on, Mr. Secretary, just with this question: I understand your 10-percent transfer you're speaking of, and I understand the additional savings you're speaking of. And I hope that we're all right, and I hope that in fact that that will do what is needed.

But let me just ask you this question: Assuming that later this year evidence comes to your attention from the States that in fact with home heating oil, let us say, at $1.40 or $1.45 a gallon, which is not beyond belief; and that the people in my State, who have in some cases which I know of fixed incomes of less than $7,000 a year, whose home heating costs this past winter, which was a fairly cold winter, was in the vicinity of $2,400 a year; and in fact, it is obvious with administrative savings and the 10-percent switch and all other savings, that there is just not enough money for these people to heat their homes—do I have your assurance that your Department and you personally consider this of a high enough priority to address the Congress with a new finding to see if we can find the funds necessary to keep the people in the Northeast from freezing?

Secretary SCHWEIKER. You certainly do have my assurance, Senator. I think it's a high-priority program. I think it's critical in terms of people's survival. If this mechanism is inadequate to protect people under those circumstances, we would certainly come back with additional recommendations.

Senator RUDMAN. I appreciate that, because I believe this administration is very compassionate about human beings. I think sometimes that image has not been portrayed properly, either because of the failure of the administration to portray it or a misconstruction of the administration's position by the media.

I am glad to hear you say that this morning, because I have been telling the people of New Hampshire I do not think this administration will ignore old people and poor people who are literally freezing in their homes. Thank you very much.

Secretary SCHWEIKER. Thank you.

Senator HATFIELD [presiding]. Mr. Secretary, I am very happy to welcome you here to the committee this morning. I understand you have already observed that had you stayed in the Senate, you would have been sitting in this chair.

Secretary SCHWEIKER. I just said I guess I made my exit too soon. But it is a joy to see you, and Chairman Schmitt there. It does my heart good.

SOCIAL SCIENCE RESEARCH

Senator HATFIELD. Senator Schmitt, Senator Rudman, and others on this committee are doing a very excellent job.

May I turn to an article that was written in the Wall Street Journal, the subject that it addressed, and that is what appears to be the administration's shift away from the social science research.

In fiscal year 1982, the administration is requesting, I believe, about 20 percent of the funds appropriated for fiscal year 1981 throughout the budget in the area of social science research. An illustration is in the area of alcoholism and drug abuse. The social science research, I believe, has proven that it can be of helpful assistance in determining causal relationships and assist in prevention of the disease.

Now, since the administration has been stressing disease prevention, isn't this somewhat of a contradiction between stated priorities versus actual policy?

Secretary SCHWEIKER. Mr. Chairman, I think I should go back a little bit to explain about our budget process. Initially, OMB had made a recommendation that would have cut even more money in this area. And I had to determine what we could do to meet our commitments in terms of meeting budget constraints——

Senator HATFIELD. Excuse me, Mr. Secretary. The 5-minute warning—I will read your answer that you will proceed to give, I presume, for the record. I will hope to return for some other questions.

Will you excuse me, please?

Secretary SCHWEIKER. I understand, Mr. Chairman.

[A brief recess was taken.]

Senator SCHMITT. Please go ahead.

Secretary SCHWEIKER. Initially there was an even larger cut proposed for these programs. The only way I was able to appeal for restoration of funds was to separate biomedical research from social research. That isn't a priority that I would like to see established, because I think there are some very good social research programs, just as there are some very good biomedical research programs. But it was an argument with which I was able to win restoration of some of the money involved.

So I think social science research funding has to be viewed in the light of taking in our belts and of budget constraints, not necessarily in the light of making a definite judgment on overall social research versus overall biomedical research. I think to do so would bring about a wrong conclusion. It just happened that separating the two was a way that I was able to get more money back into the ADAMHA program.

Senator SCHMITT. Mr. Secretary, let me draw for a moment in this area on my past experience as a geologist, which is another example of a science that has far more variables than you can solve with the variable equations. That is, there isn't enough hard scientific information to give you definitive answers, objective answers to many geological questions. It was far more that way a few decades ago than it is today. Social science is sort of in the same place that the geological science was, and some biological sciences were many decades ago, in that you have so many variables that it takes good judgment in the field to sort these through and come to answers that actually help people.

It's not quantitative, it's qualitative. Now there's been some criticism about laboratory research and that kind of environment in the social sciences as being out of touch with the problems being investigated in the field, and if we were really going to concentrate on social science research, it should be field-oriented research, rather than laboratory. It doesn't mean there wouldn't be some laboratory research, but we ought to have that kind of a bias.

How do you react to that?

Secretary SCHWEIKER. Let me say this. This budget which we put together in a matter of 3 or 4 weeks to meet deadlines for the Budget Committees and the authorizing committees, was developed under tremendous pressure and in a much shorter timeframe than I would like to have available. I would hope that in our next budget cycle, I will have an opportunity to study this particular issue. We had to give a quick shorthand answer to this issue, instead of a sophisticated selective answer. I would certainly be willing, in the coming fiscal year to see if we can have a more sophisticated, more selective definition of priorities than we had this year.

Senator SCHMITT. The subcommittee has made the same commitment to many groups, and we will make it to you personally, that when we get through this cycle, we want to go back and revisit issues such as this and try to understand them better.

On the positive side of it, in the medical sciences, prior to the 1930's, they were dependent largely on the judgment and intuition of the person out in the field, the provider, to properly treat a disease, but they were also accumulating a vast amount of information, observational information about various diseases which was available then, when suddenly antibiotics came on the scene for very rapid introduction of a quantitative treatment of something that had been treated qualitatively or subjectively up until that time.

I have the same feeling that will happen in social sciences at some point in the future, but that we must be out there collecting the basic information, the basic intuition and experience that is necessary before some quantitative solutions can be applied.

So we will get into this more deeply later, and I appreciate your interest in it, sir.

Secretary SCHWEIKER. We would like to work with you on it. I'm not satisfied with the shorthand definition that we initially used, myself.

FIELD AND LABORATORY RESEARCH

Senator SCHMITT. But you do agree with this distinction between field and laboratory research, particularly in an area where the number of variables, because you're dealing with human beings, is so great that it's difficult to quantify them. I'm not saying it's impossible, but I'm saying it's difficult.

Secretary SCHWEIKER. I certainly do, and that's exactly the basis for our thinking.

BLOCK GRANT TRANSITION

Senator SCHMITT. Mr. Secretary, back to the issue of block grants. It is your judgment that in most cases the States have an adequate bureacracy to begin the transition into a block grant——

Secretary SCHWEIKER. I could only account for the four block grants I'm proposing. Yes, States do because there is a nucleus in each of these block grants of some State program they have now. If I were the Governor, I would take that nucleus and just give the existing State agencies a little more authority and more jurisdiction.

Senator SCHMITT. Have you or the staff done a State-by-State analysis.

Secretary SCHWEIKER. We have only in the sense that we looked at our grant awards program and how the States function in the State grant award program. On the basis of that, we really feel there is a pretty good infrastructure there. You know the State structure is called something different from the block grant title, but it's in place and awarding grants now. So the structure is there.

Now the only answer we do not know is whether or not some States can simply administratively make a change. In some States, there might be a statutory requirement which would require further legislation for such changes to be made, but other States may make the change administratively, it could be a very quick shift. But those that have to make it statutorily could present more of a problem.

Senator SCHMITT. Would it be possible for our record to get a summary of the information you have on a State-by-State breakout, recognizing it's not complete, and I would not expect it to be complete?

Secretary SCHWEIKER. Yes; the method of changing to block grants is done on the basis of what the State mechanism is for dispensing these funds now. We can supply that.

Senator SCHMITT. I think it would be of interest to each member of the subcommittee to have that.

[The information follows:]

The Department has not gathered information on State administrative structures in the past. We are in the process of developing State profiles in reference to the block grants and can provide that information to the subcommittee staff as soon as it is available.

INTERIM MEASURE

Secretary SCHWEIKER. One other point I want to make, because I think you have a valid concern. That is that if we find that States are not capable of going into the block grant, and Congress has passed such a bill, we would be willing to provide them technical assistance and backup support from the people we have here, until that transition can occur. So we would suggest that as a possible interim measure. We are still going to have some categorical grant staff available until the categorical programs are phased out.

We can keep them until the States feel comfortable with what they are doing. We can help them or supply some help in making that shift, if that's a feasible way to proceed. I'm just suggesting that possibility.

Senator SCHMITT. Is there a particular shop in your organization that would be responsible for providing that kind of technical assistance?

Secretary SCHWEIKER. It would depend on the nature of the block grant. In other words, for example, within the social services block grant, these programs would be under my Assistant Secretary for Human Development. Under the health block grants, these would either be under my prevention services staff or under my top health services people.

Senator SCHMITT. Are they now in the process of pulling together the necessary management team that would be required to react to a State request on a particular block grant?

Secretary SCHWEIKER. Yes, the responsibility for studying this problem would be in the Planning and Evaluation Office; and, yes, we are attempting to do it there. We have the Assistant Secretary for Planning and Evaluation. That's where these block grant concepts originated, and that's where the responsibility would lie. We are in the process of dealing with that issue.

I'm talking about planning and formulating, but you are questioning implementation. I'm not quite sure which one we're talking about.

CONTACT POINT FOR BLOCK GRANTS

Senator SCHMITT. For each of your block grants, what we'd like to have for the record is the point of contact in the administration, in your Department, to whom or to which the State would go, if they wanted to work with you in the transition period.

Secretary SCHWEIKER. We do have a transition task force, but I think what you are asking would be under our Planning and Evaluation Designee, Mr. Rubin.

Senator SCHMITT. And that would apply to any of the four block grants?

Secretary SCHWEIKER. That would apply to any of the four block grants.

Senator SCHMITT. If New Mexico was having a problem with transition, then they would contact that Planning and Evaluation Task Force, in order to get technical assistance, and how to implement the block grants during transition?

Secretary SCHWEIKER. Yes.

Senator SCHMITT. Does that have a regional component to it? Is there an arm out in Dallas or somewhere?

Secretary SCHWEIKER. There is no reason why we can't use our regional offices. I forget which is the closest to you.

Senator SCHMITT. Dallas, I think. But I only use it as an example.

Secretary SCHWEIKER. We can utilize our regional operations to make that service available. Right now it's in the planning and formulation stage. We'd have to have a delivery arm.

Senator SCHMITT. But you would expect before the transition is actually required that any State could contact a regional office and find somebody to talk to about the transition, about their special problems of transition?

Secretary SCHWEIKER. I think it would have two aspects. If the problem is highly technical and very specialized in nature, we'd probably want to use someone from Washington. If it's of a more administrative, broader, more generalized nature, we would probably use our regional people. But we will have them available, whether it's someone in Washington or someone in the regional office.

Senator SCHMITT. And you expect that to be handled within your existing personnel ceilings and administrative overhead costs?

Secretary SCHWEIKER. Yes; the only thing that might happen is a delay in our reductions in force until the transition takes place. But we don't need additional personnel for that.

CIVIL RIGHTS ENFORCEMENT

Senator SCHMITT. How do you see the question of civil rights enforcement interfacing with a block grant proposal?

Secretary SCHWEIKER. Mr. Chairman, we are not shifting that in any way, I believe. I don't have my staff person here who has been handling it, but I do believe that we are using the language from the community services program and basically repeating that to assure that we continue that civil rights responsibility. I believe the language we are going to be using is from the community services law.

Senator SCHMITT. Which would have the effect of doing what, as you understand it? Please elaborate.

Secretary SCHWEIKER. Just continuing the status quo, in terms of our civil rights responsibility.

Senator SCHMITT. So they would be—obviously, you would hope that the State offices of civil rights would pick up the majority of the burden, all of it, if they could?

Secretary SCHWEIKER. We would still have the ultimate responsibility under the block grant program.

Senator SCHMITT. But you would be responsive under the block grant program to complaints in the investigation?

Secretary SCHWEIKER. For any of these programs; that's right.

Senator SCHMITT. But I presume you'll be working with the States to try to help them assume that burden?

Secretary SCHWEIKER. But if there is a flagrant violation and we feel that somebody is not doing his job right, then our Department would have the ultimate responsibility and would utilize it.

Senator SCHMITT. Have you done an analysis to determine the amount of Federal civil rights compliance reviews that would be reduced under the block grant program?

Secretary SCHWEIKER. We certainly would hope and think that it would, because we believe the Federal Government should give States more flexibility, more administrative responsibility, and more opportunity for their own initiatives and leadership. That is certainly our intent. We did have a cut of about 66 positions out of 590 positions in the Office of Civil Rights with that transfer of responsibility to the States in mind.

ELIMINATION OF DUPLICATION OF PROGRAMS

Senator SCHMITT. The programs proposed for block grants are purported to overlap and duplicate other programs and services provided. I assume you agree with this, because that's one of the basic justifications of a block grant system.

Do you have some specific examples that would help illustrate to the committee the kinds of duplication you think you can eliminate?

Secretary SCHWEIKER. There are several that come to mind. GAO found in an audit 1 or 2 years ago that the city of Philadelphia had a Get Set program which we were running under Head Start, and the Department of Agriculture had a school lunch program. We found out we both were paying the same bill for the school lunch program. We were paying it through Get Set and they were paying it under school lunch. The school was getting paid twice for lunches everyday.

This is typical, I think, of the kind of thing that you can get into. I think one other area is family planning. For example, from our account there are about seven mechanisms for delivering family planning services. Now, I happen to support family planning, and we are going to pass that responsibility on to the States, but there are seven specific programs that deal with family planning.

We can deliver that kind of service more effectively than through seven separate conduits. Maybe some of them are new, but it's hard for me to believe that seven are needed.

Senator SCHMITT. I think the subcommittee would agree with you in general terms. Could you provide for our record for each of the blocks that you are looking at, an indication of where you think overlap does occur and would be eliminated by the block grant approach?

Secretary SCHWEIKER. Right.

Senator SCHMITT. And any estimates of cost savings that you see will result from the block grant approach.

Secretary SCHWEIKER. OK.

[The information follows:]

We have prepared a table showing some of the overlaps (see below), for selected services. As the table shows, overlap is endemic among the programs to be block granted. However, it must be recognized that many of the programs deliver services specific to the population served (e.g., counseling to sudden infant death families).

In some cases these overlaps involve outright duplication of services (e.g., the same family receiving food subsidies from several sources for the same meals). In others, several different agencies provide the same services although not to the same family (e.g., family planning services can be delivered by as many as eight different agencies). These problems arise in large part from the separate administrative, organizational, and service channels involved. The existing categorical structure simply prohibits consolidation of service delivery by the States. Thus, it would be a monumental task for any State to attempt to centralize information and referral services scattered in 40 or more programs, since these and many other services are legally mandated to be delivered by a categorical program. And even if the State can solve such a problem, this requires extraordinary continuing staff burdens to negotiate, monitor, and coordinate interprogram agreements. Such duplication not only involves waste, but also reduces services effectiveness in many cases.

We have no estimate of the potential dollar savings involved, but there could be considerable—undoubtedly in the tens of millions nationwide, at the very least.

SERVICES OVERLAP IN SELECTED CATEGORIAL PROGRAMS INCLUDED IN BLOCK GRANTS

	INFORMATION & REFERRAL	COUNSELING	PRE-NATAL CARE	FAMILY PLANNING	TRANSPOR-TATION	FOOD	DAY CARE	REHAB. SERVICES	EMERGENCY SHELTER	CONSUMER EDUCATION
HEALTH BLOCK										
Community Health Centers	X	X	X	X	X		X			X
Primary Health Care	X	X	X	X	X		X	X		X
Black Lung Services	X	X						X		X
Migrant Health Services	X	X	X	X	X	X	X	X	X	X
Home Health Services	X	X			X					X
Maternal & Child Health	X	X	X	X	X	X	X	X		X
Hemophilia	X	X	X							X
Sudden Infant Death	X	X								X
Emergency Medical Services	X	X			X					X
Community Mental Health Ctrs	X	X	X		X		X	X	X	X
Mental Health Services	X	X			X		X	X	X	X
Drug Abuse	X	X	X				X	X	X	X
Alcoholism	X	X	X		X		X	X	X	X
HEALTH PREVENTION										
High Blood Pressure Control	X	X								X
Health Incentive Grants	X	X		X						X
Risk Reduction & Health Ed.	X	X								X
Venereal Disease	X	X	X							X
Fluoridation	X									X
Rat Control	X									X
Lead-Based Poisoning Prev.	X	X								X
Genetic Disease	X	X	X	X						X
Family Planning	X	X								X
Adolescent Health	X	X	X	X	X		X	X		

	INFORMATION & REFERRAL	COUNSELING	PRE-NATAL CARE	FAMILY PLANNING	TRANSPOR-TATION	FOOD	DAY CARE	REHAB. SERVICES	EMERGENCY SHELTER	CONSUMER EDUCATION
ENERGY AND EMERGENCY ASSISTANCE										
Emergency Assistance	X	X			X		X		X	
Energy Assistance	X	X								X
SOCIAL SERVICES										
Title XX	X	X	X	X	X	X	X	X	X	X
Child Welfare	X	X					X		X	X
Foster Care	X	X							X	X
Child Abuse	X	X			X		X	X	X	X
Adoption Assistance	X	X								X
Runaway Youth	X	X						X	X	X
Developmental Disabilities	X	X			X	X	X	X		X
Community Services Admin.	X	X			X	X	X	X	X	X
Rehabilitation Services	X	X			X			X		X

BLOCK GRANT PROPOSAL

Senator SCHMITT. You've had a chance, I believe, to talk to the authorizing committee in both Houses about the block grant approach?

Secretary SCHWEIKER. I haven't done it in the Senate; I've done it in the House.

Senator SCHMITT. What kind of timeframe would the administration think the block grant proposal could be moved through the Congress? Do you have an estimate?

Secretary SCHWEIKER. We had sent our block grant proposal to OMB about 3 weeks ago, and we expect to have it back from OMB today or tomorrow, and hopefully to the Congress by tomorrow or Friday. Therefore, we hope to have them available to the Congress by this week.

Senator SCHMITT. You indicated earlier, your rescission proposals assume the block grants in some cases will be authorized, as does your 1982 budget proposal. I hate to go into "what ifs," but as you recall in the appropriation committee we had to deal with the world as it is, not with the way we wish it to be. Do you have alternatives to suggest to the committee, if for some reason the block grant proposal is not authorized by the time we must reach markup?

Secretary SCHWEIKER. Mr. Chairman, yes. There are a couple of alternatives. I know one of the alternatives is fraught with some problems legislatively, but we still have put it forth as a fallback position if the authorizing committees haven't acted by the time that the appropriations committees feel they must act. We are sending you some contingency language which basically would say something to the effect that the appropriations committee, through legislative language in the bill, would place certain programs in block grants until such time as new authorization is approved by the authorizing committees.

I prefaced my remarks by saying this alternative was controversial. By the same token, there is another alternative. I think one other alternative is that if, for any reason, block grants don't pass, then the committee would have to look at the individual programs.

I went on record with Mr. Stockman and I want to go on record with this committee, that I support the 25-percent cut in the block grant proposal. But if for any reason we must deal with individual categorical programs, my recommendation would be not to take an across-the-board 25-percent cut for all individual categorical programs. I think we should render individual judgments on those programs.

I won't quarrel with that at all. I think that's our obligation. So that is the second alternative. One thing that is important is that many of these health programs have to be reauthorized anyway because they were held up by some differences between the House and Senate versions of bills in the last Congress. A lot of these programs are expiring or have expired.

So, to some extent, the burden is on the authorizing committees anyway to authorize these programs. Now, the chairman knows and I know the staff director knows the fuss and agony we went through because our health committees had not authorized these programs in time. To some extent we have a backlog problem now for that very reason. We're going to have to face up to it one way or the other.

Senator SCHMITT. I think one value of looking at the overlap is that in some of these areas, because of overlap, we may be able to partially block by putting the money in and with report language, not legislative language, make it clear that we would expect that particular area, say family planning is a good one, to pick up the burdens of family planning in others where the funding has been reduced as a consequence. So I think there may be some of those alternatives, and as you look at the overlap question, the subcommittee would appreciate to keep that in mind and see if you have any suggestions along that line.

Coming from my previous experience, we always like to have backup contingency planning.

Secretary SCHWEIKER. I think that's quite wise.

Senator SCHMITT. Senator Abdnor, did you have some questions?

Senator ABDNOR. I'll pass.

Senator SCHMITT. Senator Rudman?

AID FOR THE HANDICAPPED

Senator RUDMAN. Mr. Secretary, just a brief question on the aid for the handicapped. As we all know, Federal law prohibits discrimination against the handicapped, and they're recipients of a great number of Federal funds. There's great controversy about the cost effectiveness of some of the proposals in terms of access to subways, for instance, in New York, or college campuses and some of the enormously expensive programs that are going to be undertaken unless section 504 of the Rehabilitation Act is, in fact, changed.

Are you going to propose that we change it?

Secretary SCHWEIKER. Do we propose to change section 504?

Senator RUDMAN. Are you going to eliminate it? There's been some talk about it.

Secretary SCHWEIKER. We are not proposing to eliminate it. In fact, it will be incorporated in our block grant proposal.

Senator RUDMAN. 504 will be?

Secretary SCHWEIKER. Yes; I think there are two factors, and I think it is very important to separate them.

Senator RUDMAN. Fine. I wish you would. I'm really interested.

Secretary SCHWEIKER. We are going to resubmit the statutory requirement of protection, and that will be the same. On the other hand, the interpretation and the actual regulation of the program can certainly be looked at in a more realistic and effective way. So, that option we keep open, but we are going to keep the basic legislative thrust.

Senator RUDMAN. So that it is possible that if a program such as equipping every subway entrance in the city of New York with an elevator shaft, which would certainly cost enormous amounts of money, it is possible through regulatory change that requirement might not be continued.

Secretary SCHWEIKER. That's possible.

Senator RUDMAN. I suppose you could say the same for those situations where there has been discussion, as you know, to equip every intercity and interstate bus with special ramping devices that would enable the handicapped—again, at enormous cost.

Secretary SCHWEIKER. I don't want to speak out for the Transportation Secretary, but the same intent would be there; yes.

Senator RUDMAN. Thank you.

Secretary SCHWEIKER. In fact, Senator, the regulatory task force, chaired by Vice President Bush, will go into a number of these specific areas, including that one, I believe. We will have an ongoing mechanism there, too.

Senator RUDMAN. Thank you.

Senator SCHMITT. Mr. Secretary, in your press release of March 10——

Senator Abdnor, did you have questions? Don't hesitate to let me know.

Senator ABDNOR. No; I don't have any.

APPROPRIATIONS AVAILABILITY

Senator SCHMITT. In your press release of March 10, Mr. Secretary, you talked about block grants and stated, "Appropriations availability will be contingent upon the enactment of the block grant legislation."

Would you explain what you meant by that?

Secretary SCHWEIKER. Yes; that was the contingency language that I was talking about earlier, Mr. Chairman. I should answer that in two ways. We have recommended language that would be appropriate if a block grant is passed. We also are recommending language that would be appropriate if the authorizing committees have not acted yet. So, we're making two recommendations. That's what we mean.

Senator SCHMITT. OK. The phrasing was a little bit unclear.

HIRING FREEZE

Mr. Secretary, we've been told that there is some unrest in the Department because of the hiring freeze. For example, we hear some laboratories at NIH are depleted and cannot be replaced, and delay in getting top level scientists and managers onboard. What is the situation now and what do you expect to happen in the near future.

Secretary SCHWEIKER. Whenever you have a hiring freeze you have unrest, Mr. Chairman. The President ordered a freeze initially and that caused a lot of concern. There has been a change now, and instead of the hiring freeze, we have a hiring ceiling.

The ceiling is similar to a freeze in that it is a very tight constraint. We do have a little more flexibility.

But to be able to hire, we have to take positions from somewhere else. We are in the process of preparing a departmental policy. We just received the President's new ceiling decision on March 19. I can lift the hiring freeze, but then I must have a fair policy that will allow the changes in positions to occur. We are giving a priority, for example, to hiring for the Public Health Service hospitals where staff have life and death functions. Even though we are proposing phaseout of the hospitals, we still have made exceptions in the hiring freeze because of the life and death nature of those jobs.

We had to give first priority to those jobs where people's lives are at stake. After that we must have some other fair allocation of positions within the ceiling. But the ceiling assumes that certain attrition rates are going to occur and it doesn't give us much flexibility. I don't want to mislead you.

Senator SCHMITT. Do you have any specific pockets within your Department where the freeze and/or the ceiling is causing difficulties—I mean problems for carrying out the fiscal year 1982 budget?

Secretary SCHWEIKER. One of the problems will be in social security. If we decide—as we recommended and I strongly support—if we decide to change the social security minimum benefit payment affecting some 3.1 million people, then we must make about 3 million hand calculations. These calculations will determine what dollar benefit these recipients do get. The information was never computerized. All we have on the computer is the $122 minimum benefit. So we must have more staff if we are to save that minimum benefit money. These extra staff will look at 3 million cases and determine what they should have gotten if the minimum benefit wasn't in effect.

So we have some significant managerial problems in implementing some of these cuts. Now, I am for the changes because they will save money, but I just want to say, "Yes, we do have some problems." We did make a request on additional staffing for SSA to the Office of Management and Budget and hopefully will have permission for relief.

Senator SCHMITT. What about personnel at NIH to administer the grant program?

Secretary SCHWEIKER. Mr. Chairman, my guess is, you will find the main problem at NIH is not so much the freeze as the salaries. NIH scientists can earn two to three times the amount of money elsewhere than they can at NIH. We are losing a couple of head people right now who are going out in the private sector. I can't blame them. I don't blame them one bit.

This is true throughout all the Government. We are really suffering from the Federal salary cap. There's absolutely no question about it. In terms of management, we're suffering, and we're certainly hurting in terms of the NIH, and I would be wrong not to say that.

SALARY CAPS

Senator SCHMITT. What is it going to take to wake the Congress up to the problem of, not their own salaries, but the salaries in the administration?

Secretary SCHWEIKER. I wish I could give you a quick answer. Maybe some kind of a decoupling mechanism.

Senator SCHMITT. But are we heading toward a major crisis situation in any of your agencies? Will there be an obvious and public breakdown of the ability to carry out their functions——

Secretary SCHWEIKER. I can't say there'd be a breakdown in services to the public, Mr. Chairman, but I can say we're really going to be hurt in terms of the quality of the people we can attract in filling the key vacancies at the top. I've already had several turndowns in some offers that I've made for top people in the non-NIH areas just because of the salary. We don't even pay their moving expenses here. If you come from California or Texas or wherever, you have horrendous moving expenses.

We're prohibited on Presidential appointments from paying even moving expenses. So when you don't pay moving expenses and then ask people to take a cut in salary, it gets to be an economic hardship.

Senator SCHMITT. Of course they get the added benefit of getting rid of all of their stock and everything else. [Laughter.]

They get all those headaches out.

Secretary SCHWEIKER. Exactly. The other problem is when I do make an offer to somebody, invariably they get a counter offer from their present employer. In one case the offer was 25 percent higher than I could pay and 25 percent higher than they were getting; so I told them I'm the best raiser of salaries there is in the private sector. [Laughter.]

So it's very tough competing with other employers. I think the answer is "Yes," we are heading for problems. Whether it's a crisis that's going to be here in 6 months or a year, I can't tell you. But it really is a severe problem to keep these high quality scientists who are much in demand and who can go out and get double and triple their salaries. I would think that maybe the decoupling option is something we ought to look at.

I just don't know any other answer because I've been through that battle so many times and raising the cap on salaries has failed. It seems to me that maybe decoupling is a possibility.

Senator SCHMITT. Well, I've tried to sell that up here and have been unsuccessful.

Secretary SCHWEIKER. I know. I realize how difficult it is to sell.

Senator SCHMITT. I'm just afraid, and the reason I ask is if we can anticipate some major crisis, not create one, it might be the kind of catalyst we need in order to sell the coupling.

Secretary SCHWEIKER. We need to do something, Mr. Chairman.

FRAUD, WASTE, AND ABUSE

Senator SCHMITT. You, of course, and your Department will be deeply involved in the fight against the three horsemen, fraud, waste, and abuse. How are you organizing internally in order to contribute signifi-cantly to that fight?

Secretary SCHWEIKER. Well, I recruited a top person who I think is well qualified for the Inspector General's position. Although that person hasn't yet been announced or received final clearance, I have every reason to believe that he will. I think that we're going to have a very effective Inspector General, which is important.

Senator SCHMITT. Does he meet the initial basic criteria of being "meaner than a junkyard dog." [Laughter.]

Secretary SCHWEIKER. I'm not sure if I can put him totally in that category, but he's pretty tough. His experience and reputation I think will show that.

Then, in addition, we have another program that the Department has been working on to eliminate internal waste through management and budget techniques. We have a goal, for example, of a $2 billion management savings in this fiscal year, and a $3.1 billion goal in 1982. I have every reason to believe we will meet our $2 billion goal in this fiscal year. We did save about $1 billion in 1979, and $1.4 billion in 1980. But I think we still ought to do better than this.

There is going to be another mechanism that the President has set up. This is the Council on Integrity and Efficiency. It will be chaired by the Deputy Director of OMB with the Inspector Generals being members. Through this mechanism, there will be a concerted effort to integrate policy.

We will also have another interdepartmental group that will be set up to implement findings and policies. I personally have scheduled a meeting with the GAO to have them go over with me all the analyses, the reports, and the in-depth surveys they have done of my Department, to find out what we can do right and what we are doing wrong, and where we ought to put our focus. Our efforts to deal with waste involve three separate approaches, and I certainly am strongly dedicated to following through on them. I believe these are very positive tools that we have to use.

Senator SCHMITT. The last administration came up some way with the estimate that in your Department the fraud, waste, and abuse tally was like $7 billion. Do you have any idea where that figure came from, and is it all of it?

Secretary SCHWEIKER. Yes, I know where it came from, Mr. Chairman. I think half that figure can be eliminated through legislative changes.

As I recall the cost containment legislation was there, so if you believed in Federal cost containment for hospitals, for example, you would save several billion dollars. One of the least publicized facts concerning that figure is that it presupposes that Carter's cost containment bill had passed. That was a large piece of the $7 billion, but not the sole piece. That wouldn't be totally accurate today, but I don't doubt that there is a fertile field in our Department for savings. You can't spend $250 billion, the third largest budget in the world, and not be a fertile field. I'd be the first one to say we're fertile and we've got to find out what we can do.

REVIEW OF REGULATIONS

Senator SCHMITT. One of the complaints you hear out in the field from people who work in your Department is that the constantly changing regulations and form of those regulations, increases the amount of overhead that they must put in and decreases from the services that they render.

Is part of your effort going to be directed at trying to stabilize regulations so that the troops in the field, who I find mostly are dedicated people trying to serve, have a chance to do that rather than just respond to headquarters.

Secretary SCHWEIKER. There are two parts to my answer. One is that the block grant program specifically tries to accomplish this.

The second is that we will have reviews made of all of our Federal regulations. At that point, we will have an opportunity to cut down on bureaucracy and regulations. While there are numerous regulations in my Department, there is going to be a comprehensive long-range program on regulations. I think the answer will be to review regulations on an on-going basis.

Senator SCHMITT. Thank you, Mr. Secretary.

Senator Rudman?

MEDICAID

Senator RUDMAN. Thank you, Mr. Chairman.

I would like to discuss medicaid with you for a moment so I have a better understanding of the administration's plan. I'm particularly interested in what its impact will be on the States. My understanding is the administration wishes to propose a ceiling on medicaid spending, I believe beginning July 1, 1981. The current law that States, of course, administer it and the national average of Federal contribution is about 55 percent. That's a fairly accurate figure.

Under your proposal the States are supposed to gain additional flexibility in the program so as to reduce the cost of the programs and hopefully insure they won't be forced to pay more for medicaid out of their own budgets.

Now I want to talk about this additional flexibility that the State is supposed to gain. Could you amplify on that and tell us what that entails?

Secretary SCHWEIKER. Yes, Senator; one of the things that the States have complained about is that they can't manage their programs, that we have these Federal mandates that they can't manage. So there are some things that they are going to be able to do that they couldn't do before.

They are going to be able to set hospital reimbursement rates on other than a reasonable cost basis. They will be able to have competitive procurement and bulk purchasing arrangements for services such as durable medical equipment, laboratory services, and even prescription drugs. We're going to encourage the use of various types of organized health care, including HMO's. Right now there is a Federal requirement that you must have a certain mix of medicare/medicaid patients, and we're going to wipe out that requirement. If they want HMO's, that's for them to decide.

They are going to have authority to review and control admissions to nursing homes, which they don't have the authority for now. And as you probably know, long-term care accounts for about 40 percent of the medicaid budget, yet it only affects about 6 percent of the people. The States are going to have the right to promote the use of noninstitutional alternatives for long-term care, such as home health care, as opposed to the Federal Government mandating long-term institutional care as is the case now.

States will be able to target optional services, not basic services, to such populations as they deem necessary. In addition, they are going to have the right to require second opinions for surgery and for many other programs that we probably have not given them the flexibility to do. This will be accomplished in the reconciliation package which will give the Department the right to waive all of these requirements so that the States can utilize these options.

One other thing I think needs to be said. Our medicaid reduction is about $1 billion for fiscal year 1982. It is only 3 percent but everybody seems to be worried about the amount. It's only 3 percent of the total medicaid spending. I have got to believe that if you give the States the right to bulk purchase and contract services from certain hospitals, they can save that 3 percent. Besides that, we are using the deflator index for medicaid.

So I think this arrangement should allay the concerns.

FEDERAL STATUTES—MEDICAID

Senator RUDMAN. Do you see any problems at all due to the limited nature of most of the legislative sessions in the States now that were already into March? Are they going to have time to coordinate what the new Federal statutes are going to be, to amend their own medicaid statutes, which of course is going to have to be done because if they don't amend that statute in their own States, then you could easily have the situation where there was no interfacing between the two?

We have, I think, some substantial additional burdens placed on the States. I'm only now talking matters of timing more than anything else. For instance, in my State the legislative session will be done in June, and special sessions are somewhat unusual. I think that's true in many States whose legislative sessions are already complete.

Secretary SCHWEIKER. It's hard to give a general answer that covers all cases. We have done a preliminary survey. We're trying to get more information from the States; but we believe in most cases, the change will simply mean amending the plans of those States. In other words, each State has a State plan on file with us and each will, in effect, request a waiver for these changes. There may be some cases where that is not true. In those cases, we will work out a transition schedule and transition assistance if that is required because we don't want to be inflexible. There may be some States that can't make the changes by amending the State plan. We think most of them can.

Senator RUDMAN. Mr. Secretary, I have to leave, unfortunately. I would like to hear more of your testimony this morning but I expect to hear more this afternoon.

I have to tell you that I have been watching your staff here and I have to tell you it reminds me a little bit of watching the Indianapolis 500. There are about 9,000 questions we could ask you and I have so far timed the maximum turnaround time from subject to subject for your new briefing paper runs about 17 seconds. I think that's exemplary.

Secretary SCHWEIKER. They're a good staff; I have to admit that.

Senator SCHMITT. But you don't call them the pit crew yet, do you? [Laughter.]

Thank you, Senator.

POSITION DECREASE

Mr. Secretary, under the block grant proposal—I think they got ahold of our questions first. [Laughter.]

I'm going to start asking questions from the middle.

Under the block grant proposal and other proposals such as the closure of PHS hospitals and clinics, how many overall positions do you expect the Departments to lose?

Secretary SCHWEIKER. I think it's about 8,700 positions, as I recall.

Senator SCHMITT. 8,700?

Secretary SCHWEIKER. Yes; a big bulk of that is the Public Health Service.

Senator SCHMITT. That's from what base?

Secretary SCHWEIKER. The base is 145,224 for fiscal year 1981.

Senator SCHMITT. Can those all be handled through attrition in the near term?

Secretary SCHWEIKER. Not all of them, but a good many. Obviously, if we close the Public Health Service hospitals, that would not be handled by attrition. That would probably be a RIF of some kind. We figure maybe a half of the reduction can be handled by attrition and a half will be some kind of RIF.

In the Public Health Service hospitals, we have several possibilities. One is that some communities have expressed an interest in taking the hospitals. Another is that some private hospital groups have expressed an interest in purchasing the hospitals. So in cases like that, there may not be much of a problem at all in making sure the physical structures are put to good use.

But the bulk of the 8,700 positions is in the Public Health Service hospitals. If we're able to get a community conversion or private hospital purchase, then we eliminate a lot of that problem.

FUTURE OF PHS HOSPITALS

Senator SCHMITT. When do you think you will know what the future of each PHS hospital and clinic will be, assuming that they are closed?

Secretary SCHWEIKER. We have the legislation coming up today. On the other hand, it's hard to answer how soon Congress will dispose of the legislation; and, we can't really make very firm plans until we get a clear signal from Congress since it does require a statutory change.

Senator SCHMITT. One of the questions you'll be asked is what is the alternative.

Secretary SCHWEIKER. Right. Discussions are ongoing now with all the communities affected. We will give the community the first option of what they would like to do. If they don't come up with a proposal, then we are going to consider the purchase alternative. Within the next 1 or 2 months we ought to have some definitive indications of just what the situation will be in each community. Our first preference is to convert the PHS hospitals to community hospitals.

Senator SCHMITT. Would you keep the subcommittee informed, please, on each one as you see that you have one or more alternatives developing?

Secretary SCHWEIKER. Yes.

REORGANIZATION

Senator SCHMITT. Are you looking at a major structural reorganization within the Department?

Secretary SCHWEIKER. I wouldn't really call it a major reorganization. Some of the press accounts have made this into something it is not. It is not really a major reorganization, no, Mr. Chairman. We are looking at a few changes at the top which basically would set up under the

Secretary a Deputy Secretary, which we don't have now. We're one of the few large Departments that doesn't have that. Then under him an Under Secretary for Health, and an Under Secretary for Human Services.

That's really all we're looking at. Some of the press accounts have blown the reorganization out of proportion. It would just be a reorganization of the top structure because we do not have that division there now. With the big expenditures and with the tough managerial responsibilities, it really would warrant that kind of structure in my judgment. We will be sending a plan to Congress, but we didn't want to send one up before extension of the reorganization act is considered by the Congress. We wanted to wait until Congress signals its intent to go ahead with an extension, if it does.

Senator SCHMITT. Have you looked to see if any of the subdivisions of the Department could be spun off into agency status so that they would not be a burden to the administration of total Department activity?

Secretary SCHWEIKER. We are looking. This is a secondary level, not the level I just described. We're looking at some possible combinations. For example, we do propose that the National Center for Health Care Technology be combined with the National Center for Health Services Research. It just seems to me that that's a logical grouping. I think we do need the technology component; but we have a health services research center and technology could easily fit into that.

So there is a case where we are considering consolidation. With our health manpower proposals, we will be considering incorporating programs into the Health Resources Administration or putting them into some other component; there is another lower level decision pending. These are two or three instances where we are actively considering consolidating components. Consolidation I think would be more effective and logical than spinoffs.

NIH—INDEPENDENT AGENCY

Senator SCHMITT. Do you think there's any justification for NIH to be operated as an independent agency outside the Department?

Secretary SCHWEIKER. I personally doubt it, so much of what it does relates to health. For example, as soon as we get into something like the Mount St. Helens case, legionnaires' disease, or PCB problems, immediately you need to coordinate what CDC is doing with NIH. You must ask the other components of health delivery and research to cooperate.

I think it's more logical to integrate the services in the way that we have than to spin them off. Then I think you would have a real problem of consolidating for health emergencies, what I think is an excellent research program, with your service assessment programs, such as CDC.

Senator SCHMITT. There are inherent problems in managing a department or organization that is too large. You at the top and those that are around you, just literally do not have the human capacity to keep close tabs on everything that would ordinarily require your consideration.

Secretary SCHWEIKER. Let me say that's true, but there is the other side of that coin, Mr. Chairman. When health problems arise, it is natural that some differences develop between CDC and NIH, and one or two other components about whose area this is. If you start spinning these programs off, you will end up with a bureaucratic squabble about whose turf it is, and have a big fight. I've seen that all the time. The one advantage to having these components where they are is that whoever is the Secretary can say, "Hey, it's all the same game. We're looking at the health game. You take that job, and you take this job." But if you have independent agencies, then I think each scientific agency would tend to enlarge its turf as so often happens in any bureau, not just with scientists.

That's why I'm recommending the strengthening of management at the top—to have an Under Secretary for Health, which would elevate the NIH component somewhat beyond what it is now, and an Under Secretary for Welfare, which we would call Human Services—so that those functions on a more direct line to the NIH would have a higher visibility under the Under Secretary for Health.

But I see some real problems with setting up competing scientific bureaucracies.

Senator SCHMITT. I will say the history of NIH is far more encouraging than the history of most other scientific organizations that are immersed in what otherwise is a regulatory department. In most of the cases, when that has been done, the scientific component has gotten the short end of the stick, because Department attention is almost always monopolized by the day-to-day regulation and enforcement activities of the rest of the Department.

Do you have any feeling of why the Department seems to have been historically immune from that? Is it because Congress has been so interested in NIH, that they keep putting money into it, so it has a high visibility?

Secretary SCHWEIKER. I think you're right about it. NIH has been somewhat immune from that. I think that's a very important point.

Senator SCHMITT. Look at the Department of Energy. Look at the old AEC, some of the problems in the Department of the Interior. There just tends to be a subordination of the basic research to regulation and enforcement.

Secretary SCHWEIKER. I think the other part of it is also correct that Congress gives NIH a special attention; which I think it deserves. I think you follow the budgetary situation, and frankly, I'll be quite honest and say, if the NIH had not been in the Health and Human Services Department, it wouldn't have fared as well as it did in the budget, because NIH was one of my highest priorities. I successfully fought some very significant cuts in NIH.

If you don't have a Cabinet Secretary there to defend your budget, you're going to lose some clout in the bargaining that goes on between OMB and the Cabinet Secretary. So I think there is a lot to be said on the other side.

The other thing I forgot to mention is that you also have an overlap with FDA. Take the tampon problem. We had a real emergency there. We had to invoke FDA to make a determination to take tampons off the market. We had CDC research what the problem was and assess where the epidemiology studies were.

We had to have NIH directly institute research. I don't know how you do that with independent agencies. You have to have a Federal coalition council set up to blow whistles. So I really would have problems. I just think we would undermine what has worked pretty well, but I think we do need the structure changed at the top.

Senator SCHMITT. How much money will actually be saved by closing or transferring the responsibility of the PHS hospitals and clinics system?

Secretary SCHWEIKER. About $99 million in 1982, and that is a recurrent savings in subsequent years.

Senator SCHMITT. Won't the Government have to bear the burden of the care by other programs anyway?

Secretary SCHWEIKER. We have some figures on that that I would like to share with you, they were sort of interesting to me.

Senator SCHMITT. While your staff is looking for the figures, Mr. Secretary, I could go on to another general subject, and that's the inflation rate assumed in the overall budget.

Do you feel the historical record justifies the inflation rates that you have assumed?

Secretary SCHWEIKER. Well, I didn't assume them. OMB and the Economic Council established them. I accepted them, because I feel that that is their responsibility and because I don't have the detailed information they do on inflation rates. I accept the Economic Council's position, and I'll certainly defend it.

Senator SCHMITT. But you're going to be affected by it, if it's overly optimistic.

Secretary SCHWEIKER. No question about that. That's the way the system works, Mr. Chairman.

Senator SCHMITT. So you are assuming that they have come to the right conclusion?

Secretary SCHWEIKER. I think it was a fair balance, Mr. Chairman. We did have a discussion at the Cabinet level on this issue. The final assumptions were a compromise of honest differences of opinion between those who felt that the first assumptions were too unrealistic and should be changed, and those who felt that those assumptions didn't go far enough.

So this really was a compromise, and I guess only time will tell. It may well be too optimistic. On the other hand, if the President's economic package is adopted, and if we put these into effect, there are a lot of us, and I'm probably one, who feel we have a shot at making those assumptions become reality.

ECONOMIC OVERSIGHT HEARINGS

Senator SCHMITT. The problem is, and this was brought out in this committee's economic oversight hearings, that there's an inertia to inflation, and even if we got everything through in a very timely manner, that inertia would still be there during fiscal year 1982.

And in fact, we had a fairly general agreement among the economists that testified before us, that the CPI would average close to 12 percent through 1982. And if we're really off by 2½ or 3 percent from the administration's estimates, as you indicated in your first chart, that's a heck of an impact on your Department.

Secretary SCHWEIKER. It will certainly have a big impact on my Department, you're absolutely right. But I'm the person who has to absorb the impact rather than the one who has the initial input to the assumptions.

Mr. Chairman, I realize the economists honestly differ on this, and I saw it within our own group. I believe that the psychology of inflation is a very important factor. I don't know what percent of the factor is psychology, but there is a lot of it in inflation. If psychology is a big component of inflation, people feel prices are going up, therefore, they take on certain behaviors. If psychology is the big component, I've got to believe the dramatic medicine that President Reagan is giving the country in his economic package will have a very important effect on the people. Therefore, I tend to believe the results could be achieved, if most of his programs are implemented.

I would have to say that if his program isn't implemented, perhaps our worst fears might come to roost. If his program is implemented, I've got to believe that there's a psychological factor that might override some of the pure, economic projection.

But that's just a personal opinion, I'm not an economist.

Senator SCHMITT. I think that psychological factor may be as much as 3, maybe even 5 percent on interest rates, but I don't know of any study that indicates it might be that much on——

Secretary SCHWEIKER. Again, I'm not an economist, Mr. Chairman. I'll yield to you on that.

PHS HOSPITALS SAVINGS

Senator SCHMITT. How much money will the Government actually save on Public Health hospitals? You said $99 million.

Secretary SCHWEIKER. The figures are $99 million in the first year. Ultimately, $172 million is our savings. In addition, it's interesting that 66 percent of the inpatient services and 79 percent of our outpatient services provided by the hospital and the clinic system are reimbursable.

So what I'm saying is that there is a mechanism for protecting a lot of those people that are involved here. You won't realize savings there; however, we will get the savings out of the fact that the facility will be used as a community hospital. That's where you get the savings, and we are not subsidizing other community hospitals. I think that's a policy decision, whether we subsidize community hospitals or not. The savings will come from the subsidy to the community hospitals.

So we believe that these are real savings. As you well know, Public Health Service hospitals started back in 1790 to help the merchant seamen, because they were carriers of the plague and other communicable diseases at that time. Now all those original reasons for PHS hospitals are gone, but the program has mushroomed. It's sort of the classic case of how momentum can keep a program going. Now after 200 years, we feel it's time to change the policy.

Senator SCHMITT. If it becomes a community hospital, then the community presumably picks up some of the costs of operation. But others of those costs will be passed back to the Government in forms of medicare-medicaid assistance; right?

Secretary SCHWEIKER. Well, that's true, if the seamen qualify for medicare or medicaid, the costs certainly would be. But even with these costs, we will still save $172 million.

Senator SCHMITT. That is the net saving?

Secretary SCHWEIKER. Right.

Senator SCHMITT. Across the budget?

Secretary SCHWEIKER. Right.

MERCHANT SEAMEN CARE

Senator SCHMITT. What about the merchant seamen that are presently under their care? How will they be handled?

Secretary SCHWEIKER. Some of them have coverage now. For example, some of them work on oil rigs offshore, and for certain freighter lines that have some coverage now. The ones that probably don't have coverage now would be the small, independent businessmen, like our fishermen. I guess the answer to that is where else do we subsidize the health care of a small independent businessman? If we do it for that group, why shouldn't we do it for other groups.

The ones who are really seafarers, in the older concept, have long been taken care of by their company contracts and benefits. Others have been working the drilling rigs. They're working for the oil companies. Some of those are in these categories. However, we don't feel that we should single out a certain class of people for preferential treatment over other classes of people, because the situation of 200 years ago has changed.

AUTHORIZING LEGISLATION

Senator SCHMITT. This is another area of the Public Health Service Hospitals, where if the authorization change is not made, you may propose an alternative that there be legislation on the appropriations bill; is that correct?

Secretary SCHWEIKER. Today we will be sending up authorizing legislation for the change.

Senator SCHMITT. But you want some help in fiscal year 1981, so that you can start the phasedown.

Secretary SCHWEIKER. That's right. To start the phasedown.

NATIONAL HEALTH SERVICE CORPS STAFFING

Senator SCHMITT. For the National Health Corps, Mr. Secretary, your budget is requesting your field strength of 2,500 assignees in 1982. What is the plan for the future size of the National Health Service Corps?

Secretary SCHWEIKER. Last year, we had a level of 2,000 in the Corps. As you may recall, there was an effort to raise that by 40 percent. I opposed that effort as a Senator and felt that, in view of the budget constraints and the budget problems, it was too high an increase. I didn't feel that the 40-percent increase was warranted. Therefore, when I first became Secretary, I rescinded a reprograming that the last administration proposed to take the strength to 2,900, which was that 40-percent increase.

By the same token, I did approve and support in the budget a 500-person increase for 1982, which would be approximately a 25-percent increase.

Therefore, our proposals call for an increase of 500 slots from 2,000 to 2,500, and our intention and recommendation will be to hold it at that level for the next few years, until we assess the need beyond the 2,500.

Senator SCHMITT. Within that request of 2,500, how are you going to deal with the problem of replacing people becoming available next year, including volunteers?

Secretary SCHWEIKER. We're working on several proposals. For the next 1 or 2 years, there might be some people who want to serve in an area where there aren't enough physicians. Therefore, we intend to propose legislation that would give several options to the Secretary. One such option is that we could ask them to serve in the Department of Defense or the Veterans' Administration, where we have a shortage of physicians.

Another option is that we give them more of an incentive to take the private practice route, and a third option we are looking at is a revised, buy-up option. I guess my answer is that we are looking at four or five different ideas. I frankly think there should be no problem utilizing them, because with the VA and the Defense Department in short supply, that would seem to be a very natural place to put them. We're crying for physicians there. That would be my first reaction.

PRIVATE PRACTICE OPTION

Senator SCHMITT. We talked the other day about the problem that we have seen in New Mexico, which I suspect is similar to other States, and that is, where we have people who have settled into the community and very much want to stay, but apparently do not see any other alternatives being feasible for their personal situation.

Secretary SCHWEIKER. Of course, the real goal is to get them to go into private practice, and there's absolutely nothing to stop them. That's what we want them to do. That was the whole purpose of the program, and we keep losing sight of that. If they take the private practice option, then we have accomplished exactly what we set out to do, which is to have an underserved area served by somebody who isn't federally funded, but who is in private practice.

If more of them would take the private practice option, the problem would be solved.

Senator SCHMITT. I think we can demonstrate to you that there are a few communities in this country, maybe more than a few, where that isn't an option. There just isn't an economic base.

Secretary SCHWEIKER. We're not taking the people away from any area. In other words, the number in the field will increase, not decrease. Therefore, we're not pulling people out of the underserved areas.

RETENTION IN UNDERSERVED AREAS

Senator SCHMITT. You're not pulling slots out, but you're pulling people out. In some cases the person there now is going to have to leave to make room for a new graduate.

Secretary SCHWEIKER. Yes, unless we send the graduate somewhere else. We may decide that the person who is there now, stays, and the graduate will go someplace else.

Senator SCHMITT. What I would encourage you to do is that, and that there be some way on a case-by-case basis that that kind of decision can be made.

Secretary SCHWEIKER. We will try to be the least distruptive. I think our first priority though is to get them into private practice in the underserved areas. I would agree with you that we can't do that in all areas. In those areas I think we would prefer not to uproot the person who is there now. I think the new graduates, who have a flexibility of going anywhere, ought to go where the greatest need is. If there aren't needs in the outlying areas, then I think the Veterans' Administration and the Department of Defense needs ought to be cranked into the equation.

Senator SCHMITT. I think your plan is a good one and sounds like we are working toward satisfying the individual problems of the underserved, low-income community.

Secretary SCHWEIKER. There's one other option that is available to us. We can make an administrative change that would permit those who take the private practice option to go to low-priority HMSA's in categories III and IV, where they haven't been able to go before. So, that might be a blending of the two ideas right there. That's another option I should have mentioned, and that's a realistic option.

NHSC COMMUNITY HEALTH CENTER ASSIGNEES

Senator SCHMITT. What would you expect to happen to NHSC assignees placed in the community health centers or migrant health centers if the block grant programs cause these centers to be eliminated?

Secretary SCHWEIKER. Again, we don't believe that the centers will be eliminated by the block grant program. We just believe that we will go on supporting them in some way. I don't know if there would be any consolidation. We have, of course, migrant health centers; we have other community health centers, and I wouldn't think there should be any elimination effort. That's not our objective, and again the States also can help in this area if there's really a need to keep these centers. But that's not our intention.

Senator SCHMITT. But the State makes that decision. It could affect the Health Service Corps assignee in that area.

Secretary SCHWEIKER. We would still have an obligation to locate the NHSC people. In other words, I would treat that as two separate things.

Senator SCHMITT. Your obligation doesn't cease just because a community center is eliminated.

Secretary SCHWEIKER. To some extent it may increase. In other words, if the State makes that decision it might increase our obligation to do something more. Now, of course, we'd have to know why the State made that decision. Was there adequate service there or wasn't there.

We're going from 2,000 to 2,500 field strength in the NHSC, so it's a 25-percent increase. I can't believe that anybody who is presently in a situation where there is need will not be heard. We have 25 percent more people to locate.

REEVALUATION OF CRITERIA FOR UNDERSERVED AREA

Senator SCHMITT. Are you undertaking an internal evaluation of the criteria presently used to designate medically underserved areas?

Secretary SCHWEIKER. Yes, we are.

Senator SCHMITT. Would you discuss that briefly for us, please.

Secretary SCHWEIKER. All I can say, Mr. Chairman, is that we are undertaking a reevaluation of the criteria for both the medically underserved areas and health manpower shortage areas.

Senator SCHMITT. What do you sense is the problem? Why is a reevaluation necessary?

Secretary SCHWEIKER. The present definition includes one-third of the counties in the United States were in these underserved and shortage areas. I personally don't believe that that's the case. I think the definition was used more as a stepping stone to national health insurance.

This was to be the cadre that was going to launch national health insurance; we were going to have it all in place. That's why the 40-percent increase was included in 1 year. It was going to be used as a base for the national health insurance program. This administration doesn't believe we need a national health insurance program. Therefore, it doesn't believe it needs the manpower utilized in this way.

We do believe there is a role for the National Health Service Corps. We do believe that there are certain medically underserved areas and that we have a Federal responsibility to provide services to those areas. We also feel increasing the field strength of the NHSC by about 25 percent ought to put us somewhere near meeting that need. That is why we are redefining the criteria and assessing the program to see whether we are wrong or right in that respect.

FREQUENCY OF PRIVATE PHYSICIANS MOVING INTO RURAL AREAS

Senator SCHMITT. Why do you think private physicians are moving much more frequently now into rural settings than they have in the past?

Secretary SCHWEIKER. I think part of this is the Government's emphasis. I think if you look at Government programs, we all condemn them at times and say they don't work. However, you can see several good health programs and say they have worked. For example, I think the Hill-Burton program succeeded so well we had to turn it off. The point is, it did work; it did do the job.

I think the same thing is beginning to happen in the primary care area. I think the emphasis we have put in primary care and in training the large number of physicians now in the pipeline is beginning to pay off. Therefore, I really believe that Government support is a factor.

Also as the physician population expands, some of them will go to practice where there is less competition, because there is a proliferation of physicians in some suburban areas, which was not true when we had a doctor shortage. Now when the pendulum is swinging the other way, I think graduates with primary care specialties are looking to set up a practice where there is less competition and less overlap. But I believe there are some health manpower policies that are successful.

INNER CITY PRIMARY CARE

Senator SCHMITT. What about the inner city?

Secretary SCHWEIKER. The inner city areas aren't quite in the same category. We still have some needs there that we have to meet. I'm not totally satisfied with that yet.

Senator SCHMITT. Do you intend to make this an area for future examination?

Secretary SCHWEIKER. In our redefinition inner city needs would get important consideration. Whether we are able to retain all of the National Health Service Corps physicians in some of our inner city areas is still debatable.

Senator SCHMITT. There's a new program at the University of New Mexico getting underway and seemingly working quite well in rural primary care curriculum development. That is, they actually have a parallel tract for physicians in the medical school there to the normal medical school track which puts people in very specialized circumstances out into the rural community as part of their medical school training.

I just call that to your attention as a possible model for an inner city program in some larger cities. We don't have the inner city problem in New Mexico.

Secretary SCHWEIKER. Several of the Governors who have good health programs have told me that if they get the ability to contract their hospital services, that they will use that as a way of keeping their inner city hospitals viable and their inner city personnel intact. They will make contracts for medicaid in the inner city hospitals.

Several Governors, specifically, have said that if we give them the flexibility to put medicaid where their hospital occupancy rate is low, or the staffing is low, that they could, by their own decision, crank the urban hospital into their contractual arrangements for medicaid.

Some Governors are going to use that waiver position which we will give them to build up the urban hospital and meet some of these inner city problems. I think that's a good resource opportunity.

EFFECTS OF RESCISSIONS ON INNER CITY MEDICAL PROBLEMS

Senator SCHMITT. Your rescission packaging includes rescissions in areas that might be considered applicable to the inner city medical problem, health protection, family medicine, residencies, training, graduate training, general internal medicine, general pediatrics. Could you explain how you expect those rescissions to be picked up——

Secretary SCHWEIKER. There was a discussion with OMB in this area because their cuts went beyond what you see here. We argued that there were certain key categories that the Federal Government ought to support in this area. We are still working on the Department's health manpower legislation. We will be putting emphasis on health manpower and primary care, physician extenders, nurse practitioners, and preventative health.

We are going to try to put the emphasis where we feel the greatest need still exists. Primary care is still one of them, but we feel the capitation program like the Hill-Burton, has produced such good results, that by 1990 we will have an oversupply of doctors. Not now, but soon.

So we are trying to pull back the incentives that have successfully produced more physicians, but keep incentives in primary care and some of the other areas.

TRAINING NURSES

Senator SCHMITT. In the nursing area, we do not have an overabundance of nurses. However, the nurse loan program is proposed to be terminated. In your justification you state that "concern is shifting to problems related to the distribution of nurses and the retention of trained nurses in their profession."

How do you expect to manifest this concern?

Secretary SCHWEIKER. Having gone through a number of arguments with past administrations on this point, let me explain my views.

I sat where you sat several times in the last few years, and I heard administration witnesses say that there is no nursing shortage, therefore we didn't need the money. That is not my approach. Our argument is that we don't feel this is a productive way to meet the problem.

We believe that the real problem with nurses is not a shortage, but one of the degree of professionalism accorded their job and of pay comparable to that in other professions.

For example, we believe that the nurse practitioner is a way of elevating the status of nurses so that they have a higher status than they do now. One of the problems is that nurses are sometimes kept in lower pay or service status. By elevating the role of nurse practitioner, we begin to upgrade the profession which is a way of retaining people.

We think nurses come into the health care system and drop out because they find a higher paying job; because they don't feel they're being treated equally, commensurate with their training, or because of the sporadic shifts many of them are asked to work. We think there should be a multifocal approach. One is training nurse practitioners. Another is encouragement of innovative time and shift arrangements, because the time demands health care facilities make on nurses are unrealistic.

Senator SCHMITT. But that's because there's a shortage. Largely because there's a shortage.

Secretary SCHWEIKER. Yes and no. For example, one of the hospitals, I believe in Houston, has a new procedure where they are arranging a schedule so that a nurse can work a weekend of two 12-hour days. Nurses can work the weekend and draw a full week's pay.

Senator SCHMITT. They're looking at that in Washington, too, in the Children's Hospital.

Secretary SCHWEIKER. That's an innovative way of solving the problem of working mothers who want to be with their children during the week but can work on the weekend when Dad's home. The program gives them pretty comparable pay benefits. We think the nursing problem is more a matter of the working conditions and benefits and status of the profession than of just the numbers of nurses trained.

Senator SCHMITT. How can you help that? That's a nongovernmental decision. How are you going to help them out?

Secretary SCHWEIKER. We have $6.4 million for special nursing projects in our new proposal which we believe will encourage hospitals to develop this very kind of program. Also we are requesting $7.8 million to be spent on training nurse practitioners. I guess what we're saying is that putting money into training more and more nurses has not been productive. It puts people into the pipeline, but they drop right out after they graduate. So we're saying spend money more selectively to keep nurses in the profession. We are putting emphasis on nurse practitioners and also on the innovative nursing projects.

I think there is still a third way that we can resolve the nursing problem and that is through a reimbursement mechanism. When we present our competitive cost and reimbursement plan, we must focus on how we reimburse and recognize some of these innovative programs which affect nurses, not just raising the salary per se. We are looking at more innovative ways than before, but we admit there is a problem, and a serious one.

Senator SCHMITT. Do you have a task group working this problem now?

Secretary SCHWEIKER. I have a group headed by the Assistant Secretary for Planning and Evaluation that is working on it. I must say candidly, though, that it will be another 2 to 3 weeks until we can devote 100 percent of our time to it.

Senator SCHMITT. I understand and the members of the committee does also. That's one of the areas where we hope once we get through this, we can spend a great deal of time with you and help in anyway possible. I agree with you, the problem is much like the military problem of retaining trained enlisted men and noncommissioned officers. It's a lot cheaper to retain them than to train new enlistees.

Secretary SCHWEIKER. One of the problems is that I don't think the hospitals themselves have really dealt with this problem effectively. In other words, I think they have perpetuated the downgrading of the profession the way nurses are treated, what options of service they have, and their work hours. I think they are perpetuating a system that is draining nurses out of the profession.

I go back to the hospitals where there is some movement. In Houston, for example, there is a change. They just can't offer the same old working conditions to nurses. I think our reimbursement mechanism is going to provide incentive for hospitals to change the way they treat their nurses.

COMMUNITY HEALTH SERVICES

Senator SCHMITT. Mr. Secretary, a final question this morning, this afternoon we will move on to CDC and NIH and some of the other programs.

All the Departments and Agencies of the Federal Government are being forced to cut back staff as we have heard. Yet, it appears that you have not requested any 1981 rescissions for program support under the Bureau of Community Health Services, a $29 million program, for the time remaining in the current fiscal year. Please tell the committee how much you can still rescind and what effect it will have.

Keep in mind we're looking for the largest rescission possible.

Secretary SCHWEIKER. Let me give that to you at 2 o'clock.

SUBCOMMITTEE RECESS

Senator SCHMITT. OK. We will recess until 2 p.m. this afternoon if that's convenient, sir.

Secretary SCHWEIKER. That's fine. Thank you, Mr. Chairman.

Senator SCHMITT. We will meet again in this room to continue the questions.

[Whereupon, at 12:10 p.m., Wednesday, April 1, the subcommittee was recessed, to reconvene at 2 p.m., this same day.]

(AFTERNOON SESSION, 2:15 P.M., WEDNESDAY, APRIL 1, 1981)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF RICHARD S. SCHWEIKER, SECRETARY

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The subcommittee will come to order.

We want to take up one item with you, Mr. Secretary, and that is in your justification chart on page 18 of the Health Services Administration and CDC, the total number of U.S. Public Health Services positions that would be reduced is indicated as 10,724. I want to reconcile that number with the 8,700 that you mentioned earlier.

Secretary SCHWEIKER. Unfortunately, these are comparing different things, Mr. Chairman—10,724 is from the 1982 Carter budget for Public Health Service and the 8,700 is from the 1981 Reagan budget for the entire Department.

Senator SCHMITT. All right; 8,700 off of the actual would be 10,724 off of the Carter budget.

Secretary SCHWEIKER. Right.

Senator SCHMITT. All right. So the actual reduction is 8,700.

Secretary SCHWEIKER. The book that you just read from is 1982 Reagan versus 1982 Carter for the Public Health Service and the other figure is 1982 Reagan versus 1981 Reagan for the Department. That's what I gave you a minute ago.

Senator SCHMITT. OK, that clarifies that. Implicit in the 1981 Reagan budget is the rescission proposals, which is a reduction from Carter budget of something like 2,000.

Secretary SCHWEIKER. That sounds about right.

Senator SCHMITT. In the Center for Disease Control——

CIVIL RIGHTS

Secretary SCHWEIKER. I'm sorry. On the civil rights question I do have additional information.

Senator SCHMITT. Please go ahead.

Secretary SCHWEIKER. What we are using is the Housing and Community Development Act standard. We are adding a ban in the block grants against discrimination on the basis of race, color, national origin, handicap, or age, and then we're also including sex, which was not in that particular act. We have the language here for you to see.

HEALTH EDUCATION

Senator SCHMITT. All right. Fine.

As you know, there's been a great deal of interest on the part of some subcommittee members in the area of health education. While there seems to be a multiplicity of health education programs within HHS and some within the Department of Education, there is no centralized unit or purpose apparently for administering these programs.

In addition, the subcommittee has received criticism from various State health education programs that the money is not getting to the schools from the local State health agencies. What is the total budget for all of the health education programs within HHS for fiscal year 1982, and how do they relate to the Department of Education's programs?

Secretary SCHWEIKER. You're not talking about community health service. You're talking about health education.

Senator SCHMITT. Health education in the Center for Disease Control related to primarily elementary and secondary education.

Secretary SCHWEIKER. We have put health incentive grants and health education in the block grant program. Is that what you were referring to?

Senator SCHMITT. Is a reduction in health education a part of it?

Secretary SCHWEIKER. Yes; the health incentive grant and the risk reduction in health education is in the block grant proposal for health preventive services.

Senator SCHMITT. If the block grants are approved, there will no longer be a specific health education unit.

Secretary SCHWEIKER. Not necessarily true, Mr. Chairman.

Senator SCHMITT. Yes; you're pulling health education out of CDC to include in the block grants program.

Secretary SCHWEIKER. Yes, you're right. That is the CDC program which is included in the block grant.

OTHER HEALTH EDUCATION COMPONENTS

Senator SCHMITT. Are there other health education components within HHS besides this one?

Secretary SCHWEIKER. Yes, there are. We have smoking and health, health promotion, and physical fitness programs that are still in HHS. There is $1 million in smoking and health, $1.7 million in health promotion, $1.1 million in physical fitness and sports, and $500,000 in international health. That's right, those are the four. So there are small components in there.

Senator SCHMITT. Were those programs considered for inclusion in the block grant program?

Secretary SCHWEIKER. They were looked at, but on the basis that education about smoking is a national campaign, OMB didn't put it in the block grant. It would have been such a small amount to spread among the States that it probably would have been difficult to carry out as a separate program.

FUNDING HEALTH EDUCATION BLOCK GRANTS

Senator SCHMITT. How do you anticipate the funds allocated to health education in the block grant program will be distributed at the State level? Do you think it will go into the health or education agencies at the State level? Is there any way to anticipate what the States might do?

Secretary SCHWEIKER. Presently the health departments themselves have this money and are spending it for health education. So I guess the answer is that it would still continue to go to the health departments in some way.

While the money goes to the health departments, they must use it on a preventive health service. They have been using it on preventive health services in some of those health incentive grants and other programs.

FUNDING HEALTH EDUCATION IN DEPARTMENT OF EDUCATION

Senator SCHMITT. There is authorizing legislation that would fund health education programs at some level in the Department of Education. Do you know whether they've been funded yet?

Secretary SCHWEIKER. They may have some separate programs. You're probably right; I just don't know.

Senator SCHMITT. Have you had any opportunity to coordinate with Secretary Bell on that issue?

Secretary SCHWEIKER. Not on that particular issue; no. I don't know what happened to the education money.

BLOCK GRANT FOR HEALTH PREVENTION

Senator SCHMITT. Mr. Secretary, are you satisfied that this area of health education which is so critical, and pivotal to your prevention efforts, is going to be properly treated within the block grant program? Is it going to be properly treated relative to the Department of Education and your activities?

Secretary SCHWEIKER. Mr. Chairman, initially when OMB made the proposal, they proposed only one big block for our categorical programs. I felt that would have wiped out the prevention program, so it was I who suggested a separate category for health prevention. I really am reasonably assured that once we have a separate category for health prevention, that we will get some sustained State interest and support because the States must spend it within the block.

If we didn't have a separate block grant for health prevention, I think I would share your concern. But here is a block grant that they must utilize. I think they will want to utilize, so I believe that it will be protected.

If these programs were going to be thrown into the health service block grant, or a larger grant, no, I wouldn't be assured that preventive health programs would be supported.

DUPLICATION OF EFFORT BETWEEN DEPARTMENT OF EDUCATION AND HHS

Senator SCHMITT. This subcommittee, of course, has to look at both the education and the HHS budgets, and we will have to examine whether there is going to be a duplication of effort between the two Departments.

Secretary SCHWEIKER. I'm not sure of how much duplication or overlap there is. My guess is that there isn't much left after the budget process, but I don't know. I'd just wager there's not very much left.

Senator SCHMITT. But it doesn't appear the administration has asked for any money in the Education Department in this area, so maybe even though it's authorized, it will not be a difficulty.

If you will provide for the record a complete listing of the health education programs in your department, that will be helpful.

Secretary SCHWEIKER. There's one other part of the answer to your question. That is there is $3 million in the Department of Education for alcohol and drug education that is being put in the block grant, too. In other words, $3 million from alcohol and drug education is going into an educational block grant.

Senator SCHMITT. Within the Department of Education.

Secretary SCHWEIKER. To the State.

Senator SCHMITT. From HHS?

Secretary SCHWEIKER. No, from Education. I think that answers your previous question.

Senator SCHMITT. I don't know whether you share my concern or not, that health education programs are split between two Departments. It would be appropriate to determine whether the services can be provided through a reimbursable system.

Secretary SCHWEIKER. A lot depends, too, Mr. Chairman, on what the administration ultimately does with the Department of Education. That's the larger issue that will affect this area.

Senator SCHMITT. Do you see anyting inherently unworkable about consolidation of programs and providing for reimbursable funding if it appears that the Education Department might be a better place to offer the service?

Secretary SCHWEIKER. I see nothing wrong in consolidating the programs.

REQUEST FOR LISTING OF HHS HEALTH EDUCATION PROGRAMS

Senator SCHMITT. Did you receive my request for a table with a complete listing of health education programs within the Department?

Secretary SCHWEIKER. We will do that.

Senator SCHMITT. In addition to what you have here on this block.

[The information follows:]

It is virtually impossible to identify discretely every DHHS effort in health education and health promotion, since health education is a fundamental mandate of every health-related DHHS program. There are, however, three principal organizations within the Department of Health and Human Services which deal entirely with health education and health promotion activities as part of their operation.

1. Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary of Health/PHS.
2. Office on Smoking and Health, Office of the Assistant Secretary for Health/PHS.
3. Center for Health Promotion and Education, Centers for Disease Control.

Examples of other Department organizations which contain some type of health education activity include:

1. ADAMHA in its alcoholism, drug abuse, and stress reduction programs.
2. NIH in its cancer information and hypertension programs.
3. Administration on Aging in its drug usage and nutrition programs.
4. Administration for Children, Youth, and Families in its Head Start program.
5. Health Care Financing Administration in its Office of Beneficiary Services activity.
6. Bureau of Community Health Services, Health Service Administration in its health awareness activity.
7. Centers for Disease Control in its immunization and fluoridation programs.
8. Food and Drug Administration in its consumer awareness programs.
9. Indian Health Services in its preventive health services activity.

SHIFT IN BUDGET PRIORITIES

Senator SCHMITT. Senator Hatfield, do you have any questions?

Senator HATFIELD. Mr. Chairman, thank you.

Mr. Secretary, on the folio that you have here of charts, I would like to have you turn to the one that's entitled "Shift Budget Priorities Percent Composition of Outlays."

On this chart you have a base comparative pie for 1962, 1981, and 1984. I note that in the safety net programs it shows a growth factor of 25 percent in 1962; 37 percent in 1981; and 41 percent in 1984. Am I corresponding to the chart there?

Secretary SCHWEIKER. That's right. These aren't growth factors, though, Senator Hatfield. They are shares of the outlay pies for those years.

Senator HATFIELD. All right. But what I want to ask is, how much of that growth or how much of that changing percentage of the pie is attributed to indexing and existing statutes of laws that call for increases, and how much of it represents programmatic increases?

Secretary SCHWEIKER. Let me answer that in a couple of ways. First of all, 94 percent of the dollars in my department's budget are entitlement programs. I only have 6 percent that are not entitlement programs. In the safety net, of course, would be social security and medicare, so they would have an indexing feature.

Senator HATFIELD. But, Mr. Secretary, basically it's not a shift in priorities as much as it is an increase in part of a pie due to entitlements and statutes that are on the books now, is that not true?

Secretary SCHWEIKER. That's true, but keep in mind it was Congress that legislated the entitlements.

Senator HATFIELD. But really the shift in budget priorities here is not through a policy determination as much as it is by a statutory mandated action, entitlement directed spending, and so forth.

Secretary SCHWEIKER. I guess the point I'm trying to make is when Congress passes an entitlement, that becomes a shift in policy and a shift in priorities.

Senator HATFIELD. But what I'm really getting at is that those laws were in place before this administration came into power.

Secretary SCHWEIKER. Correct.

Senator HATFIELD. There's been no change in entitlements, no basic changes, since this administration, so this reflects basically then statutory rather than policy action as far as this administration is concerned.

Secretary SCHWEIKER. I see your point; yes.

Senator HATFIELD. Now, the other question I have relates to the Department of Defense——

Secretary SCHWEIKER. Except let me make one point, Senator Hatfield. The decision of the administration to change the safety net entitlements would be a policy decision. If they had made a policy decision to change them, then of course I wouldn't project what I did into 1984.

Senator HATFIELD. That policy decision only relates to fiscal year 1981 rescissions and fiscal year 1982, but does not exempt the possibility of such entitlements being changed by recommendation to the Congress from the administration for fiscal year 1983.

Secretary SCHWEIKER. That's correct.

DEPARTMENT OF DEFENSE VETERANS' BENEFITS

Senator HATFIELD. Department of Defense shows 44 percent in 1962; 24 percent in 1981; and 32 percent in 1984. Now, Mr. Secretary, let me ask you, in putting this pie together, did you include in the Department of Defense veterans' benefits or are they included in the so called social safety net programs?

Secretary SCHWEIKER. They're in the safety net programs.

Senator HATFIELD. Is there any computation on the relationship of the service to the national debt and its part that was created by wartime or military expenditures, or is that in all others?

Secretary SCHWEIKER. No; we list that under net interest. That's lumped under net interest.

Senator HATFIELD. That's lumped together. You haven't extrapolated that in terms of that relationship to the military versus the nondefense expenditures as it related to the national debt.

Secretary SCHWEIKER. We wouldn't have a breakdown on that, but we can get it.

Senator HATFIELD. So that if one was to look at those costs in terms of the pie that are directly attributable to military and defense programs, peace and war, that figure probably would be larger, would it not, in terms of the total pie?

Secretary SCHWEIKER. Yes; in the terms of money borrowed for the war or veterans' payments.

GRANTS FOR MEDICAL SCIENCE RESEARCH

Senator HATFIELD. Now, shifting the subject matter for a moment, we are going to continue funding basic research in the medical science field. We are going to continue providing grants and so forth, are we not?

Secretary SCHWEIKER. That's correct.

Senator HATFIELD. Now, Mr. Secretary, do we have an adequate commitment to the maintenance of research facilities that would be recipients of such grants. In other words, the grant part for research, but also the capability vis-a-vis the research laboratories and facilities that exist now mostly on univeristy campuses, science centers across this country, who are the major recipients of such grants. What is our ongoing commitment for the adequate funding or support or assistance to the maintenance of such facilities?

Secretary SCHWEIKER. Which part of the research grants are you talking about, Senator?

Senator HATFIELD. Let's turn to page 285 of the justification of the amended volume here [indicating], document volume III.

Secretary SCHWEIKER. 285.

Senator HATFIELD. Page 285.

Secretary SCHWEIKER. OK.

RESEARCH FACILITY SUPPORT PROGRAMS

Senator HATFIELD. Now, on that, it shows appropriations of 3.2 in 1980; 11.7 in 1981; and 10.3 in 1982.

First of all, could you give me an estimate of the breakdown between NIH facilities and universities and other such research——

Secretary SCHWEIKER. These are only NIH facilities, on campus.

Senator HATFIELD. These are only NIH. Now, you have—and you can help me a little bit by turning to the page where you have "facility support programs related to universities." They are granted through NIH?

Secretary SCHWEIKER. They're granted through NIH. The problem is that it is so hard to trace where the impact is, that I don't believe we have a summary of it.

Senator HATFIELD. Can you provide that for the record, then—let me re-phrase the question.

In the outgoing program administered through NIH, basic facility research and facility support, what is the trend line there, and can you provide an assessment as to the adequacy of that kind of funding.

Secretary SCHWEIKER. We'll try to provide what you want, Mr. Chairman. The problem is that when we give a grant, we necessarily don't have a breakdown of how much is for research salaries and how much is for university costs. So we will try to get you what you want.

[The information follows:]

EXTRAMURAL RESEARCH FACILITIES

The table on the following page lists the amounts budgeted by NIH from FY 1975 through 1980 and estimates for FY 1981 and 1982 for the renovation and construction of extramural research facilities.

The NIH itself has not conducted a recent evaluation of the adequacy of extramural research facilities. However, an up-to-date assessment does appear in the March 6, 1981 issue of Science magazine. An article therein, entitled "Instrumentation Needs of Research Institutions," contains the following analysis:

> Without adequate facilities, research programs cannot operate at full capacity. In the 1960's, substantial federal resources were available for the construction and renovation of research facilities. However, such support has diminished in recent years, placing an increasing strain on institutional funds.
>
> Frequently there is a long delay between the decision to construct or renovate facilities and the acquisition of the necessary funds. With today's inflation this delay can substantially reduce what the funds can accomplish. At a midwestern public university, inflation has effectively eliminated $250,000 from a planned $2 million wing to be added to a bacteriology department building; at a western public university, the time it is taking to raise $4 million for a biology building will likely cost at least one of its four floors. At one eastern private university, a new biology facility vital to the strengthening of the department has had to be abandoned.
>
> Aging facilities impede research efforts. Recently, a malfunctioning distillation system in the zoology department building at a midwestern public university paralyzed research in the building for over a week. At a private university in the East, a promising program in contraception research was abandoned because the university could not meet new federal requirements for housing the dogs used in the research.
>
> Animal facilities, greenhouses, and herbaria are particularly difficult to maintain. These facilities, tied as they usually are to building construction, are becoming old, but replacement and renovation funds are difficult to obtain through federal grants and are becoming extremely difficult to obtain from local sources. (p. 1015)

In light of these findings, it appears that universitities are struggling to maintain adequate research facilities.

NATIONAL INSTITUTES OF HEALTH
Support for Extramural Research Facilities

	ACTUAL						ESTIMATES	
	1975	1976	1977	1978	1979	1980	1981	1982
Universities	$25,057,804	$16,742,679	$13,253,904	$12,016,320	$11,931,152	$7,111,010	$4,982,754	$5,425,913
Alt/Renovation	2,138,629	2,118,099	2,131,391	2,126,057	4,423,543	2,748,336	2,965,538	3,206,158
New Construction	22,919,175	14,624,580	11,122,513	9,890,263	7,507,709	4,362,674	2,017,216	2,219,755
Research Institution	$7,423,196	$8,792,622	$4,378,450	$1,880,878	$3,823,893	$5,315,031	$2,711,231	$2,974,806
Alt/Renovation	342,371	185,650	100,950	201,150	379,234	411,358	443,868	479,867
New Construction	7,080,825	8,606,972	4,277,500	1,679,728	3,444,659	4,903,673	2,267,363	2,494,939
Hospitals	$279,011	$459,956	$750,757	$43,375	$1,068,075	$1,673,546	$851,692	$934,236
Alt/Renovation	279,011	191,508	150,770	45,375	68,075	126,290	136,271	147,273
New Construction	---	268,448	599,987	---	1,000,000	1,547,256	715,421	786,963
Other	$96,300	$2,650	$42,275	$460,409	$53,100	$9,350	$10,088	$10,904
Alt/Renovation	96,300	2,650	42,275	30,400	53,100	9,350	10,088	10,904
New Construction	---	---	---	430,000	---	---	---	---
Total	$32,856,311	$25,997,907	$18,425,386	$14,402,982	$16,876,220	$14,108,937	$8,555,765	$9,345,859
Alt/Renovation	2,856,311	2,497,907	2,425,386	2,402,982	4,923,952	3,295,334	3,555,765	3,844,202
New Construction	30,000,000	23,500,000	16,000,000	12,000,000	11,952,268	10,813,603	5,000,000	5,501,657

RELATING RESEARCH GRANT PROGRAMS TO THE CAPABILITY OF RESEARCH CENTERS

Senator HATFIELD. It raises, though, a very serious question as to how we relate the grant program for research projects to the adequacy or capability of research centers to really exercise those grants with competency, with quality, as is determined in part to the availability of support for facility.

I remember when we used to hear about these great increases in research moneys for certain scientific programs, when we were on this great binge for spending more money for basic scientific research, and it ended up with two problems: One was we were overly dependent on in-house research, governmental in-house; and second, we hadn't really surveyed the adequacy of existing facilities to absorb the grant money. So what we had to do was back off and address the problem of facilities in order to accommodate the increases of grants for research. I am really raising this in that same context.

I am pleased to see the administration is continuing its basic research grant program here, but I also believe I am correct when you extrapolate the figures, that we have substantially reduced the Federal commitment in support facilities.

Secretary SCHWEIKER. Let me answer your question in two parts, Mr. Chairman.

First of all, one of the highest priorities I had in my budget negotiations with OMB was to keep our basic biomedical research programs intact. After a lot of bargaining back and forth and even though NIH is a nonentitlement program, you'll find that NIH has the highest percentage increase of nonentitlement programs in my Department.

We were successful in getting an increase for the NIH. To the extent NIH funds these facilities, there would not be a significant decrease in dollars.

By the same token, the National Science Foundation, which provides funds to some of these institutions took a very substantial cut. If the money was coming to the facility through NSF, there would be a decrease; if it was coming through NIH, it would be at maximum only a slight decrease.

By the same token, we do not fund instruction or rehabilitation programs in our center grants. I believe that the National Science Foundation may indirectly. That, of course, is not my Department, but that may be a significant decrease.

NATIONAL SCIENCE FOUNDATION AND NIH PROGRAM COORDINATION

Senator HATFIELD. I appreciate the fact you maintain a national perspective in all these research programs, rather than letting the geographic entities confuse the issue: namely, that we're granting something to States as a State matter—research in biomedical areas is, of course, of national concern.

What really I suppose I should ask is whether or not there is that kind of coordination between National Science Foundation and NIH and your programs, because, again, unless we keep the two parts of this objective very carefully coordinated, we get far ahead in grants for research and get very far behind in the adequacy of facilities. I take my own University of Oregon Medical Science Center as a good example.

Frankly, in many areas they could not absorb or really accept programmatic research grants, because of the need for upgrading facilities. They just could not absorb them. and yet, they are available, and they just can't accept them, nor can they apply for them.

So it seems to me we need more careful coordination, and it may be through your own experience here on this committee and now as Secretary of Human Resources that we can get better coordination between facility and project, grants, research, and then the adequacy of the research laboratories.

Secretary SCHWEIKER. The National Science Foundation, as you know, comes under the Science Advisor to the President. I do not believe that office has been filled yet. By the same token, I have been asked to chair a Cabinet Council on Human Resources. So I think at such time as the Science Advisor position is filled, on matters of this kind, we would incorporate that person into our Cabinet council. This type of coordination gets bypassed unless we have a broader outlook.

Senator HATFIELD. Thank you very much, Mr. Chairman.

Senator SCHMITT. Senator Rudman?

BLOCK GRANT PROPOSALS

Senator RUDMAN. Mr. Secretary, I would like to discuss with you the block grants as they are now proposed by the administration.

I heard you testify this morning, then heard you at lunch again, and I couldn't agree with you more that your response to OMB's original proposal for a complete consolidation of all the block grants—I believe was the right proposal. It seems to me that the original proposal, although possibly easier to administer, was probably simplistic to a fault, and probably would not have worked.

I want to talk about these four grants, with particular concern that I have, and I expect that you will have the same concern as each of these programs gets into the jurisdictional area of the committees that will be writing them. Health service, of course, is one; second is called preventative health service; third, energy and emergency assistance; and fourth, social services. Those four block grants, my understanding is those grants will go to the States.

To the extent that States do have apparatus to administer them now, via the State health and welfare department, as in my own State, or the State health department as in my State, they would be so administered. I have two questions.

Question No. 1: What happens to the vast Federal apparatus, the bureaucracy that's been set up regionally, to have jurisdiction and administrative control and audit function over all of these that had heretofore been categorical grants? That's my first question.

Secretary SCHWEIKER. We have proposals in our budget message to reduce staffing commensurately if these categorical programs are shifted to block grants to the States. We would leave some staffing at the Federal level, but it would be significantly reduced from the previous levels. There would be, for example, 2,600 jobs in 1981 for these programs versus 160 jobs in 1982 if the block grants are passed. That is a decrease of about 2,450 positions.

In terms of the regional apparatus, we've had some discussions on this. No final decision has been made. Obviously these programs would not take the regional support they did before, so I suspect this reduction will be at the regional level. But that decision hasn't been made yet.

BLOCK GRANT PERFORMANCE STANDARD FORMULA

Senator RUDMAN. The second question I think is by far the most important question, and I will predict that what is behind this question will probably give us all the most trouble in the coming 6 months.

It's already apparent to me in talking to people from my State—and I have talked to some of my colleagues, and I am sure you have heard the same thing—the concern expressed by many is that although theoretically, and I guess philosophically, under the block grant program you have to have faith in the States when you give them these grants in these four areas. You expect the States to deal accordingly.

There is a concern expressed by many municipal, town, and county officials around the country, and I have talked to many from New England, that if this now goes to State governments that there must be some kind of a formula performance standard built in to prevent two things from happening:

First, that States do not take too high a percentage of these block grants for administrative costs, which, in reality, will be underwriting other general administrative costs of the State agencies other than those directly attributable to this program; and second, that the pass-through procedure will be unincumbered, will be free from administrative mazes, and most importantly will deliver the funds down to the cities, towns, and counties in the way that it must do.

I think this is a very critical area, and I think unless a great deal of attention is paid to it, with a lot of consultation, with a great many people, that we are going to run afoul of many political subdivisions who have great concern. I would like just your general response, knowing that this is a difficult problem and one in which your own thinking may not have been fully developed by this time.

Secretary SCHWEIKER. Senator, I think it is a critical and difficult problem. We did wrestle with it for about a week in our budget formulation. We finally decided not to specify characteristics of the block grant programs that would relate to administrative costs and procedures, because we thought it was an extremely complex and difficult area. However, I want to say that I recognize this is a problem, and I think there ought to be some fairness and equity in how we would proceed.

Therefore, we are not hidebound on this, and if the committee in its wisdom has some suggestions to make for consideration, we would certainly be willing to listen to them, because I want to make sure that this Department is responsive to legitimate needs in implementing any policy proposals.

ADMINISTRATIVE COST LIMITATIONS

Senator RUDMAN. Just a couple of thoughts on that, Mr. Secretary.

First, it seems to me there ought to be, based on the experience of your agency, some way to assess administrative cost limitations on what the States can, in fact, charge off for administrative costs. I think at the very minimum that might have to be done.

Secretary SCHWEIKER. Well, our experience has been that different programs have different administrative burdens. Then you get into the question, do you write an average burden in, or do you write one for each categorical program. That gets cumbersome. The administrative burden is somewhere in the range of 10 percent plus.

SOLICITING INPUT FROM THE PUBLIC SECTOR

Senator RUDMAN. Second thing that I think you have to write in is—in my view, at least, and then I have a third suggestion—is that you have got to be very careful that State agencies do not use some of these funds which they will now call within their block for what will fall a State-run program, as opposed to what has heretofore been categorical grants, going down to the cities, towns, and counties, to use as they want for maybe similar purposes. But it's the old game of grabbing power where the money is. And I see a real concern in that area in my State. And I'll give you some detail on that.

I think the third thing, and I just want to comment on it, as I intend to submit to you through your staff a series of proposals addressing this very critical problem from town, city and county leaders within the State of New Hampshire. It seems to me you would be well advised to solicit input from people in other States around this country who have the same concerns, because I think there is some wisdom out there, and some concern, in fact a great deal of concern, and hopefully before this legislation gets cast in concrete, there might be some suggestions made to you by municipal, county, town officials around the country that might give you some guidance as to some regulations that you could work in.

I am sure you will also want to consult with the National Governors Conference.

But it just seems to me, Mr. Secretary, that from what I have been hearing, there's a great fear out there about putting this money directly into the State governments for disposition as they wish, and I implore you to tread with it very carefully.

Secretary SCHWEIKER. Senator, I have met with some of the top executives of the different associations that represent these units of Government, and I proposed to them that if they could make some recommendations to us, we would take a look at them.

One of the problems, as you well know, is to get a consensus among the different units as to what fairness would be. But I will reiterate that we are open on this point.

Senator RUDMAN. Thank you.

SEARCH FOR HIGHER EFFICIENCY

Senator SCHMITT. Thank you, Senator.

Mr. Secretary, I think from Senator Rudman's questions it's clear that we've got a lot of thinking to do about the block grant. It's based on an inherent faith in the Federal system, and a belief that the States, given the responsibility, will quickly or gradually begin to exercise that responsibility in a way more responsibly than the Federal Government has.

As our friend Winston Churchill said, "Change is often mistaken for progress."

And in many people's mind, this kind of change is not going to be progress, but rather, having to deal with a State bureaucracy that is now without any constraints from the Federal Government. I don't have an answer, but I think we have to search for some ways in which at least in transition, people can be reassured that the programs will continue, but at a higher efficiency than they have in the past.

Secretary SCHWEIKER. That's why we certainly are reasonable in terms of looking at anything the committee might propose on these block grants. We really are quite open, and I recognize the responsibility that you have to provide proposals. I think we have a responsibility to look at your proposals and be open-minded about them.

Senator SCHMITT. I think you will probably get some from the subcommittee. No question about that. And whether we can agree among ourselves, I don't know, but we will try.

UPGRADING SKILLS OF TEACHERS

When you give us the information on health education programs, would you include in your list the Public Health Service also? It provides instruction programs for upgrading the skills of teachers whose responsibility it is to teach health.

Secretary SCHWEIKER. All right, we will.

ECONOMIC COST OF HEALTH PROBLEMS

Senator SCHMITT. It seems, clear, many of the health problems that the Center for Disease Control focuses on are in a real sense self-inflicted. They can be attributed to smoking, bad diet, excessive drinking, soft drug and hard drug use, driving at high speeds, sexual carelessness, tooth care neglect, lack of exercise, and in some areas, a lack of prevention against childhood diseases.

In the February testimony of the Department, we were told the economic costs of smoking is somewhere in the neighborhood of $17 to $26 billion annually, at least in 1979.

And the economic cost of alcohol abuse exceeded $39 billion in the mid-1970's.

Do you believe those numbers are in the ball park?

Secretary SCHWEIKER. I would say they are large enough that whether they are in the ball park or not they should alarm us and concern us. I'm not sure how accurate they are, but I am sure the problem is of that magnitude.

Senator SCHMITT. Even if they are a factor of two, it is considerable.

Secretary SCHWEIKER. Therefore, the answer is, "Yes."

HEALTH PROMOTION AND RISK REDUCTION PLANS

Senator SCHMITT. What then are your plans with regard to health promotion and risk reduction in these areas, recognizing the tremendous leverage that a little bit of progress can have with numbers of that magnitude?

Most of that cost is borne by the Federal Government, is it not, one way or the other?

Secretary SCHWEIKER. Much of it is, Mr. Chairman, no question about it.

First of all you should understand that initially OMB zeroed out the section of the budget that deals with smoking and health. I appealed and got 50 percent of the money back. Therefore, I share your concern.

Second, there is about $30 million that we use in NIH research that relates to smoking, and there has been no cut in that. That's ongoing. So, our basic research in this area is continuing unabated. I think that's important.

Senator SCHMITT. Isn't most of that research on the consequences of smoking, rather than how you prevent people from smoking?

Secretary SCHWEIKER. It probably is.

One of the things that I am going to try to do is to get NIH research more prevention oriented. That's one of my high priorities, to make sure that a significant part of our whole NIH structure gets into prevention activities. That's one of the answers to your question.

The other part relates to the fact that we are going to present a cost containment plan that will include a reimbursement procedure. Under this plan, we are going to allow reimbursement and/or tax deductions for groups and companies that carry out preventive health programs. This would include nonsmoking campaigns and alcohol abuse programs.

Therefore, we are going to work in the prevention area very closely. We can encourage the private sector through tax incentives to get into that area, and we would certainly do that.

USE OF FEDERAL EXCISE TAXES TO SHARE BURDEN OF COSTS OF HEALTH SERVICES

Senator SCHMITT. Have you discussed with others in the Cabinet, such as Secretary Regan, the possibility of Federal excise taxes in the areas of tobacco use and alcohol use. The taxes should help bear the burden of the cost to the health services.

Secretary SCHWEIKER. We certainly explored that problem with OMB but without success to date. However, I had not talked with Secretary Regan, because that type of issue is usually resolved by OMB. We weren't too successful.

Senator SCHMITT. Do you believe the Government can indefinitely bear the cost of bad habits in the population?

EMPHASIZE PREVENTION PROGRAMS

Secretary SCHWEIKER. I believe we are foolish to continue to bear that cost. I believe we should restructure our research programs so that prevention is near the top of the list instead of near the bottom.

I intend to do that as much as I can at NIH. I think we should also change the reimbursement policies to reflect this philosophy.

Third, I think we should undertake educational programs as much as we can. I have some groups coming to see me soon that want to bring the private sector into this area under the auspices of our Department.

I think that is an excellent way to go and I am not only going to explore their proposal, but I am going to see if we can set up a program that would encourage the private sector to work with our Department in setting up preventive programs. We have begun two such programs in the Department, one in our health prevention office and another in conjunction with the Red Cross and some volunteer service groups.

Senator SCHMITT. Senator Rudman is leaving to vote, in 5 minutes I will leave to vote, and we will not lose more than a couple of minutes in the process.

Secretary SCHWEIKER. It's a relief not to get up when those bells ring. So, I sympathize with you. [Laughter.]

Senator SCHMITT. Mr. Secretary, we would like to work closely with you on the issue of prevention, not only in the kinds of programs we have discussed, but in the NIH program. You and I agree completely on the issue.

Secretary SCHWEIKER. Let me say this, I think your role can be very helpful because one of our problems is that we don't want to be accused of interferring with scientific research. We are going to have to be very thoughtful on how to emphasize this focus at NIH without disturbing their peer review system.

But, I really think it needs to be done, and I think with some thoughtfulness and with your cooperation, we might be able to do that.

Senator SCHMITT. One of the most important things we can do for prevention, is have a far better basic understanding of the human biological processes. The concept of monochromal antibodies, the concepts of interferon are all basic scientific phenomena which lead to prevention. So, there is a good deal already going on, and more that could form the basis for preventive technologies and preventive treatment.

There are probably some other areas where we have tended to focus on the development of expensive treatments without sufficient concentration on how to prevent having to apply the treatment. Certainly kidney disease is one example.

More and more, I think we are headed toward some exciting things happening in diabetes treatment; that is curative treatment, or at least it prevents the long-term costs that diabetics must incur.

I would just presume that your prevention block grant is a step, at least administratively, in the direction of emphasizing this, even though you and I both would agree that we really haven't made much progress in this budget toward a major reorientation toward prevention.

Secretary SCHWEIKER. I think the key here, Mr. Chairman, is that this is a step that has never been taken before. And that is, to single out prevention per se.

Obviously, the funding is not what I would like to see. By the same token, we now have a lever; we have a place to go; we have a focal point. I am hopeful we can use that block grant as a base to expand in the future when we don't have some of the budgetary problems we do now.

NATIONAL DISEASE SURVEILLANCE PROGRAM

Senator SCHMITT. OK.

On the immunization program.

Secretary SCHWEIKER. There's one other component. This information relates back to health education and health promotion.

CDC will keep its lead role in the preventive health area. For example, CDC does have its national disease surveillance program to detect patterns of disease transmission across State boundaries. Also CDC will continue to provide assistance to State and local governments in field and lab investigations of epidemic outbreaks, and in upgrading the quality of State and local clinical labs.

It is also going to continue its in-house capacity for the study of venereal diseases and clinical standards for VD testing.

They have a national health prevention component that we are not interfering with or infringing upon. That program is vital and we want to preserve it and try to strengthen it.

IMMUNIZATION PROGRAM

Senator SCHMITT. OK, sir.

What, specific goals do you have for the immunization program this year?

Any significant changes over the last year or so?

Secretary SCHWEIKER. As I probably mentioned earlier, we had initially put it in the block grant with the proviso that it have a maintenance-of-effort provision. We felt we could keep our national focus through that.

OMB decided that they didn't want a maintenance effort provision in any block grant, so they reversed their position on the immunization program and went back to a categorical grant.

We are seeking about $18.1 million for immunization and with that, we will be able to maintain the present 90-percent immunization rate of children in the children's disease category. Beyond that, we will have to be selective as to what we do.

Senator SCHMITT. Are there any significant problems you see now, or on the horizon in this program?

Secretary SCHWEIKER. I think the only problem immediately is that there is a general laxness and belief that we have conquered most of these childhood diseases, therefore, citizens are reluctant to being immunized.

Senator SCHMITT. Do you still see that?

Secretary SCHWEIKER. Well, it is still a factor and we have to deal with that. I think that's health education as well as prevention.

EFFECTS OF RESCISSIONS ON CHRONIC DISEASES STUDIES

Senator SCHMITT. With respect to chronic diseases, what would be the effect of the $494,000 rescission on studies relating to arthritis, and also on Federal efforts to maintain adequate supplies of cadaver kidneys?

Secretary SCHWEIKER. Is this the rescission for fiscal year 1980 that we are talking about?

Senator SCHMITT. 1981; yes, sir.

For example, would the rescission eliminate Federal involvement in this kidney supply effort?

Secretary SCHWEIKER. There is basically $18,790,000 of which we are rescinding $494,000. We would try to meet this rescission on the basis of eliminating some——

Senator SCHMITT. While you are looking, I will run and vote. Senator Rudman will be back in a moment.

[A brief recess was taken.]

Senator RUDMAN [presiding]. We're back in session now.

Secretary SCHWEIKER. OK. I will respond to the question concerning the kidney supply effort.

Basically, we believe that we can still do what we were doing before, even with the rescission. We have found the new targeted donor approach is more productive than the scattershot approach we used. We believe that we will have enough donors—in fact, the same supply with less money, just because we have a better and more effective way of targeting donors. Before we had a scattergun approach that wasn't too cost effective. Therefore, according to our calculations, we will not be lacking the donors that we need for this program.

NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

Senator RUDMAN. I want to move on now to a question about the National Institute of Occupational Safety and Health.

Do you think that institute has been effective in minimizing the incidence of illness and injury in the workplace?

Secretary SCHWEIKER. This is NIOSH you're talking about?

Senator RUDMAN. That's correct. I didn't use the acronym, because I don't understand half of them myself.

Secretary SCHWEIKER. That's my trouble. I've been here too long. I understand the acronyms and I forget what they stand for.

Senator RUDMAN. I heard someone testify the other day for 25 minutes, no prepositions at all. All we had were a bunch of acronyms.

Secretary SCHWEIKER. We believe that NIOSH should be a scientific research agency and not an enforcement agency. I think this is a philosophical difference with the past administration.

The first director and his successor treated NIOSH as basically a research agency. That certainly was the way that I thought it was set up when I voted for it and I thought there was a need for it. But the last administration turned it into an enforcement agency in many respects and also a training program.

We really believe that the enforcement aspect belongs to OSHA. In the past, we had two agencies basically doing the same thing.

We don't believe NIOSH should be an enforcement agency or a training program. We believe it should be a research agency.

So the money is to refocus the agency, to cut out the training and the enforcement aspects that have occurred in the last few years, and to refocus on the basic research for which we feel there is need.

ELIMINATION OF TRAINING FUNDS FOR UNIVERSITIES

Senator RUDMAN. Then I expect that answer would probably cover a question related to whether or not you favor elimination of the aid to the universities to furnish them funds to aid in the training in this area?

Secretary SCHWEIKER. Yes, that's right. We just don't think it's primarily a training agency. We think it is a basic research agency. We badly need the basic research component.

If you followed the recent Supreme Court decision on occupational health, our position was not upheld because our basic research wasn't on track. I think we've got to get back to that basic research function if we're going to be effective.

FLUORIDATION

Senator RUDMAN. Mr. Secretary, let's go on from that subject to fluoridation for a moment, if we can. Back in 1945, fluoridation was introduced as a public health measure in this country. It continues to be introduced. It's still a controversial subject among some segments of the population nationally, as well as in my own State.

I think I have two questions here.

No. 1, What is your view of fluoridation?

Second, do you think the Federal Government should continue to be in the position of sponsoring it? Or something that should be left to the States?

Secretary SCHWEIKER. We are making that part of the block grant program, so that really becomes a State decision.

I think there is an element of controversy with fluoridation, I don't think we can avoid the controversy, because there are some honest differences of opinion.

In the past there was a reaction to fluoridation that did not have much scientific basis. Now we see problems with other chemicals, for example, in the chlorination of our water supply, we now know, when you chlorinate a water supply, there are some carcinogenic problems. It does give rise to the suspicion that if you can cause some problems with chlorinating the water supply, certainly fluoridation, which is a similar process, with a chemical in the same family, might possibly present some of the same problems.

We aren't making a definitive judgment on that scientific controversy, except to say that we feel that the States should have an option to support or not support fluoridation programs. We think it has been very well received in some areas and fought against in other areas; we're leaving it up to the States.

We do retain about a $1.7 million in-house technical assistance capability, but there is some controversy about that. We don't want to deny that.

Senator RUDMAN. What is that 1.7? That was my next question. You've got some lipreaders down there. Can you tell us what that is, that 1.7, because we're looking at this all-purpose table here, and that appeared.

Secretary SCHWEIKER. This is technical assistance for those communities and States that want to carry out fluoridation programs, so that we can provide a technical framework for them.

Senator RUDMAN. So you certainly have retained the capability to the extent people want to ask you for it, you can have that help available?

Secretary SCHWEIKER. Yes; it provides technical consultation, assistance to the States and local health agencies and private organizations for implementing the operation and management of the local fluoridation programs.

REDUCING INCIDENCE OF HOSPITAL INFECTION

Senator RUDMAN. I would like to move on to CDC just for a moment, technology development application. The administration has proposed a rescission of $450,000 plus in CDC research in reducing the incidence of hospital infection.

Since the Federal Government through medicare and medicaid pays a significant portion of hospital costs, particularly low-income and elderly patients, since the 2 million common infections are transmitted each year in community acute care facilities, isn't it in the best interests of the Federal Government to continue to try to eliminate such infections? And I don't quite understand the rescission.

Secretary SCHWEIKER. We are leaving some money. You are right we are reducing it about $1 million. We are leaving some $1.9 million for funding a national surveillance program. We believe that it is primarily a hospital problem, because we now have the technology to deal with those infections. It's a matter of seeing that hospitals are sterile in terms of the viruses or bacteria that cause these infections. We believe that it's primarily a hospital control program and should be handled locally. But we do admit there's a national component, and hospitals ought to have a place to go for advice and consultation. But we don't think we should run it. We should be available for technical consultation.

NIH NATIONAL RESEARCH SERVICE AWARDS

Senator RUDMAN. Mr. Secretary, I think what we'll now do is turn generally to a whole area on NIH, if you want to be prepared for those questions.

I will talk, first, about institutional allowances. Section 472B(5) of the Public Health Service Act, as amended, states that national research service award shall be made to individual for research or research training that "shall also provide for payments to be made to the institution for the cost of support services, provided such individual by such institution."

The law goes on to say the amount of such payments shall bear a direct relationship to the reasonable costs of the institution for establishing and maintaining the quality of its biomedical and biochemical research and training programs.

In light of this requirement, on what basis was the decision made to terminate costs of institutional allowances and indirect costs on NRSA awards.

Second, doesn't the law have to be changed first?

Secretary SCHWEIKER. To the first part of the question, this was something that NIH was paying the institutions that nobody else in the public or private sector was paying. We were giving an extra payment for certain institutional costs.

But I think the fallacy is that we don't do it in our other public programs. In other words, the National Science Foundation and the Department of Education, that have similar training awards programs, do not offer this kind of additional support. Therefore, we were doing something that neither the National Science Foundation nor the Department of Education were doing.

In addition, nobody in the private sector pays for institutional costs. So we were giving a special subsidy from the NIH to these groups that neither the National Science Foundation or the Education Department or private industry were giving and we just didn't feel that that was justifiable expense.

I sat down with Dr. Fredrickson and discussed this entire issue of how much of NIH funding we were going to cut. I said, "Look, Doctor, we're going to have to give something up here if we're going to save the basic biomedical thrust."

I asked him, frankly, for his advice, and he had no hesitancy in saying that this was the area we could give up with the least pain.

When I saw the other private and Government groups weren't making this payment, I felt it probably was. That's why we made that decision.

Senator RUDMAN. Well——

Secretary SCHWEIKER. I'm sure some institutions don't like it, because nobody likes to have a bonus cutback, but we're paying an extra amount that nobody else is paying.

Senator RUDMAN. Let me, just before the chairman resumes his chair, just restate one part of the question. I understand your rationale, your logic. I expect you probably are right. I have a copy of the law here, 472B(5). That is a law, not a regulation.

AUTHORIZING LEGISLATION FOR NATIONAL RESEARCH SERVICE AWARDS

I just want to repeat the question.

Do you not need legislative change before you, in fact, do that? And if, in fact, the answer to that is, "Yes," then don't we have a problem in taking the money out if that law isn't changed before we mark this up?

And I'll turn it back to Senator Schmitt.

Secretary SCHWEIKER. Let me say, Mr. Chairman, your premise is correct. It does have to be a statutory change. But being an old Appropriations Committee member, we know you can put language in that limits expenditures under certain conditions, without being authorizing language to an appropriation bill. So this is what we are proposing, that you put in a "but-none-of-the-money-can-be-spent" limitation.

Senator RUDMAN. But we will have to do something.

Secretary SCHWEIKER. You are right. It does require legislative action, but it could be done as appropriation language under the conditions that appropriation language can be written.

Senator RUDMAN. Thank you.

Senator SCHMITT [presiding]. Having a former Attorney General on this committee is almost the same as having a former geologist on it.

IMPACT OF RESCISSIONS ON NIH INSTITUTIONAL ASSISTANCE AND INDIRECT COSTS

Of the $126 million in NIH funds you propose to rescind in fiscal year 1981, how much is related to your proposal to end institutional allowances and indirect costs?

Secretary SCHWEIKER. $51.1 million.

Senator SCHMITT. $51.1 million?

Secretary SCHWEIKER. Yes; about 40 percent of it.

Senator SCHMITT. In seeking to eliminate institutional allowances and indirect costs for NIH training, the administration has argued, "No such support is provided to the institutions on behalf of nonfederally supported students."

Would you clarify that statement since nonfederally supported students do not comprise a Federal priority?

Secretary SCHWEIKER. The National Science Foundation doesn't give this bonus and neither does the Education Department when they give training grants. We're the only Federal organization that does it. And as I said a moment ago, it's sort of the icing on the cake. If we had the icing to pass out to everybody, I could justify it.

Senator SCHMITT. I see what that statement is referring to then. It wasn't clear.

Secretary SCHWEIKER. If we had money, I certainly think it's a nice benefit to give some of the institutions.

NIH APPROPRIATIONS LANGUAGE

Senator RUDMAN. I just want to follow that, because, you know, we're going to have to do something along these lines. In looking at some language—I don't know if this has ever been tested in the courts—but, for instance, here's a footnote on the National Cancer Institute that says "for carrying out to the extent not otherwise provided in the Public Health Service Act with respect to cancer, notwithstanding the provisions of," and then a whole long Federal citation. Is that the kind of language you're talking about in this?

Secretary SCHWEIKER. Basically, yes.

Senator RUDMAN. I just submit to you, Mr. Secretary, that that language may be more than simply that. And I think we ought to give some very careful attention, with counsel for your agency and our own staff, if again, as I would like to see——

Secretary SCHWEIKER. Or perhaps the language should read, "None of the funds may be spent, et cetera."

Senator RUDMAN. Then you get into another problem, which we don't have to discuss today. But I just would like to have some consultation. I'm going to try to work with our subcommittee chairman here on our staff to see that what we finally put out of here is in good crisp legal form so everybody understands what we did. I think it would be a refreshing change from some of the Federal legislation I've been forced to look at over the past 12 years.

Secretary SCHWEIKER. You should have been here when Senator Magnuson was here. [Laughter.]

It would have made an interesting byplay, I'll tell you that.

But I agree with your point.

MANPOWER FOR SCIENTIFIC RESEARCH

Senator SCHMITT. Mr. Secretary, we have a major problem in this country overall, in the availability of manpower with advanced degrees for various scientific and engineering research efforts.

It's my understanding that this is most clearly manifested in the NIH area by a lack of clinical researchers, although I presume that you are feeling some of the problems of the lack of computer scientists also.

Would you summarize the situation as you see it with respect to manpower? I'm speaking of something other than the salary problem. In terms of whether the manpower exists and the intensity of competition throughout the entire economy for an insufficient supply.

Secretary SCHWEIKER. In any particular fields, Mr. Chairman?

Senator SCHMITT. Just generally, or you may be specific, of course, if you wish. Do you sense an impact of this shortage in your program?

Secretary SCHWEIKER. I think the most immediate impact we have is one with regard to salary. That's our answer.

Senator SCHMITT. You think that overwhelms all other factors?

Secretary SCHWEIKER. It really does; it obscures the other problem. Maybe that's an excuse. Maybe we come back and hide behind it a little bit because it's so overwhelming. And to some extent it biases an objective analysis, because that's the first thing that's thrown up as a roadblock.

NONCOMPETITIVE SALARIES

Senator SCHMITT. That's one of the reasons your salaries are so noncompetitive is that the competition is so intense on the outside that the private sector salaries are being bid up very, very rapidly.

Secretary SCHWEIKER. Yes.

I think it's another side of the same question. You're right. That's exactly what's happening, and we can't compete. And it's because there's a shortage in certain clinical areas that we can't meet.

Senator SCHMITT. But it also appears from the work done in one of my other subcommittees, Science, Technology, and Space, that even if you were competitive, you would have a shortfall.

Secretary SCHWEIKER. I wouldn't doubt that at all. It's just that we never had the luxury to get to that stage.

Senator SCHMITT. At least not recently.

So as far as you are concerned, all other considerations are academic until you get salary relief.

NO SHORTAGE OF GRANTEES

Secretary SCHWEIKER. With one exception—there is not a shortage of people who apply for NIH research grants. In other words, in terms of the specialists and clinicians who want to have an NIH grant, we have plenty of people who apply, so there's no shortage in that respect. That's where your salary problem is not a factor.

On the other hand, there may be a shortage of M.D.'s going into biomedical research. I want to mention that. Some of the same reasons such as salary problems apply here.

GRANT PROGRAM PERSONNEL SHORTAGE

Senator SCHMITT. Is there an overall shortage of personnel to carry out the functions of the grant—not the grantee themselves, but the personnel, the graduate students and the technicians that would work with grantees on the grant programs?

Secretary SCHWEIKER. I haven't seen the detailed breakdown of that. I'm sure Dr. Fredrickson would have the latest figures, which we could probably give you on it. By the same token, it doesn't reflect itself in the number of grants we have available for funding.

Senator SCHMITT. The basic grant program is more than bid up by the number of people who would like to work on those grants.

UNIVERSITIES AFFECTED BY BUDGET REDUCTIONS

How many schools will be affected by your proposal to cut institution allowances and indirect costs in fiscal year 1981?

Secretary SCHWEIKER. About 222 biomedical training institutions are affected.

Senator SCHMITT. Are they concentrated in any particular area, or are they pretty well distributed?

Secretary SCHWEIKER. I can read you a few of the major ones affected: University of Washington, Seattle, has $1.3 million; Harvard, $1.3 million; Johns Hopkins, $1.3 million; Yale, $1.2 million; Washington University at St. Louis, $1.2 million; University of Pennsylvania, $1.2 million; University of Chicago, $1.1 million; Duke, $1.1 million; University of California, San Francisco, $1.1 million.

Senator SCHMITT. These schools, the ones you have read so far, are fairly large institutions, and one would expect them to feel the bite a little bit less than the smaller ones; was that taken into consideration?

Secretary SCHWEIKER. I read those off, because they're the largest recipients.

Senator SCHMITT. They're also about the largest institutions.

Secretary SCHWEIKER. Right. So you're going down the ladder. The first 20, for example—let me give you the lowest of the first 20 which is the University of Alabama. These are in order of descending dollar amounts and that's $600,000. After you get through the first 20, you are talking of figures less than $600,000.

Senator SCHMITT. Wouldn't the proportion of the money relative to the total budgets be quite large?

Secretary SCHWEIKER. Well, you'd have to go down the list further. We just have the first 20 listed here.

Senator SCHMITT. Do you understand what I'm saying, Secretary Schweiker?

Secretary SCHWEIKER. Yes, I understand; but it depends how small the institutions are when you get to the bottom. You know we have a good number of top research institutions in this country.

Senator SCHMITT. My question is, Did you take into account the technical research funds available versus those that will be lost as a result of this action?

Secretary SCHWEIKER. Keep in mind, Mr. Chairman, these are major research grants and, frankly, small schools do not seek to get or have the base to get some of these research grants, because they are of a rather significant level, and they don't attempt to compete.

That's why I should really have the rest of the list to see how far down it goes, but I will wager there are not too many small colleges involved.

Senator SCHMITT. Your statement is true not only for research but also for the research training grants.

Secretary SCHWEIKER. This was just training that I was talking about. I'm sorry. I don't know what your initial question was, but I was answering it for research training.

REDUCTIONS IN SPECIAL TRAINING ALLOWANCES

Senator SCHMITT. If your proposal for cutting back on special training allowances goes through, you may have to ask some schools to return money they've already received; is that true?

Secretary SCHWEIKER. Apparently there is about $6 million that would fall into that category. They may not have spent it, but it has been obligated.

Senator SCHMITT. Do you anticipate this being a problem?

Secretary SCHWEIKER. There could be some legal problems, depending on the timing of the rescission and the nature of the budget amendments. We can supply the committee with some additional information that will help them make a decision in this area. I think you probably should have that.

Senator SCHMITT. Yes, please do.

[The information follows:]

LIST OF RESEARCH CUTS

Question: For each NIH Institute where there is a 1981 rescission, please provide comprehensive information on how the proposed cut will impact on specific research efforts. For example, how will specific Cancer, Heart or Diabetes research projects be affected by any cutback in new or continuing research grants, contracts, intramural research, etc. To what extent will research results be delayed by your proposed rescissions? Be specific.

Answer: A major portion of the rescission amount is in the area of research training, which is supported by all the Institutes. Slightly fewer trainees will be supported in FY 1981 than in FY 1980; however, the major emphasis of the rescission is contained in the proposal to eliminate institutional allowances and indirect costs. It is unknown at this time what impact these reductions may have on the ability of institutions to support trainees in biomedical research. All trainees will continue to receive awards for their tuition, fees, and stipends.

With regard to specific research efforts, the impact of the proposed rescission on each NIH Institute is described in the following paragraphs.

National Cancer Institute

Reductions will be taken in the following NCI research activities: biological and chemical carcinogenesis, nutrition, immunology, tumor biology, preclinical and clinical treatment, and diagnostic research. These activities are supported through research grants and contracts and within the NCI's intramural research program.

When making reductions in FY 1981, NCI tried to maintain a balance between research grants, contracts, intramural research, and training so that essential research would not be impaired or delayed.

National Heart, Lung, and Blood Institute

In the area of research project grants, Requests for Applications for the competitive continuation of a targeted program in sudden cardiac death and basic studies of cardiomyopathies and pulmonary endothelial research will be reduced. The delay will curtail somewhat the advance of new research ideas and new fundamental knowledge, postpone the acquisition of results, and delay implementation of strategies to solve specific disease problems.

The Institute will negotiate downwards the commitments of all 59 of its research center grants by approximately 5%. Thus, all ongoing center programs will be continued, but at a reduced level of support. The reductions will result in a decreased level of activity in such areas as the Sickle Cell Centers, which have provided valuable research, training, and counselling to the black community, and in Specialized Centers of Research (SCOR) focused on major health problems in the heart, lung, and blood areas. This will result in a reduction in a major cardiovascular initiative, the Atherosclerosis SCOR program, which has been successful in providing basic and clinical advances over the past decade; and the diminution of four pulmonary programs that have contributed to our increased understanding of major lung diseases.

Reductions will also be made in all contract programs including commitments to certain clinical trials, particularly the MILIS (Multicenter Investigation of Limitation of Infarct Size).

National Institute of Dental Research

As a result of the 1981 rescission the NIDR intramural programs will terminate the taste research activities and will delay procurement of certain needed research instrumentation. The rescission will also prevent the award of approximately six new research project grants. These projects span several areas such as: studies of the mechanisms of bone resorption; investigations of oral bacterial adherance mechanisms; identification and classification of microorganisms associated with peridontal disease; studies of wound healing with reference to acquired oralfacial defects; and studies of corrosion and toxicity of restorative materials.

National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases

The proposed rescission for this Institute will impact primarily in the areas of research grants and the diabetes centers. Except for the latter, all the reductions are spread throughout the Institute's program categories: arthritis and related diseases, musculoskeletal diseases, skin diseases, diabetes, endocrinology and endocrine disorders, metabolic diseases, digestive diseases, nutrition, kidney disease and urology, hematology, and intramural research. When distributed across all programs, the impact should not be substantial.

National Institute of Neurological, and Communicative Disorders and Stroke

Priority will be given by the NINCDS to support of research project grants, with only slightly fewer new awards being made.

The reduction in research and development contracts will eliminate a study of the endocrinological parameters (hormone production) in experimental anticonvulsant drugs. Also a new stroke clinical research program will not be initiated. Work under this contract would determine the availability and efficacy of advanced care and treatment of stroke patients through controlled clinical trials and relevant clinical research. A clinical trial on the pharmacologic prevention of post-traumatic epilepsy will be reduced to one-third of the requirements or not funded at all.

The reduction in the Intramural Research Program will delay the full implementation of the Positron Emission Tomography (PETT) Program including purchase of peripheral equipment. Development of the communicative disorders clinical research branch will be delayed. Further development of brain tumor research will be delayed, including development of brain tumor models and the evaluation of long-term effects of brain tumors and rehabilitation of patients.

National Institute of Allergy and Infectious Diseases

Competing research project grants awarded by NIAID will be reduced slightly, mostly in the area of infectious diseases. The net effect is to reduce research on technologies and advances in obtaining solutions to such problems as herpes genitalis, gonorrhea, or bacterial and viral infections of the lung or brain.

National Institute of General Medical Sciences

Because of a number of dramatic breakthroughs that have occurred in the past few years, the field of genetics research is currently the most exciting area within the scope of the NIGMS. By the use of modern molecular genetics, scientists are now able to analyze human cells in a manner not heretofore possible; we are, as a result, moving more rapidly toward an understanding of cancer, autoimmune disorders, thalassemia, and the formation of abnormal hemaglobins. The proposed reduction in the NIGMS research budget for 1981 will necessarily have some impact on the rate of progress we continue to make in this area. However, we will continue to fund the very best applications within available funds.

A similar situation exists within the Institute's Cellular and Molecular Basis of Disease Program. Here again, rapid advances have been made in the past few years. Our knowledge of how the cell membrane is structured and how it functions, for example, promises to open up a number of areas for fruitful investigation. Embedded in the membrane are various types of receptor molecules, which interact with specific molecules from distant parts of the whole organism; these receptors are known to be involved in a wide range of biochemical processes, including everything from the secretion of hormones to the body's reaction to various drugs. Studies regarding such receptors are also of great importance to an understanding of the mechanisms involved in such disorders as diabetes, atherosclerosis, and cancer. There will be a modest reduction in the number of research grants supported in this area.

National Institute of Child Health and Human Development

The NICHD supports a wide range of research activities in the areas of Population and in Research for Mothers and Children. Research in both areas will be affected by the rescission. Reductions will be made in research project grants, research centers, research and development contracts, and intramural research. Promising areas of research that are susceptible to impact include the treatment of high risk pregnancies and high risk infants, prevention of premature labor, identification of children with learning disabilities, clinical applications of human growth hormone (hGH), and contraceptive development and contraceptive evaluation studies.

National Eye Institute

Examples of NEI grant-supported research that may be affected include: studies to develop better treatments for tear abnormalities, a leading cause of visual impairment and chronic discomfort among the elderly; tissue culture studies to better understand the normal and cataractous lens; proposals to develop means of preventing and treating glaucoma secondary to ocular injury; and projects to improve the techniques used to study the development and functioning of the visual nervous system components.

Ongoing contracts to determine the effectiveness of early treatment of diabetic retinopathy will be funded at a reduced level. As a result, fewer clinics may have to be supported and the rate at which patients could be recruited into the study will be slowed. This may have the effect of extending the amount of time needed to gather and analyze data and may delay the communication of research to clinicians.

National Institute of Environmental Health Sciences

The rescission will reduce research funds available to NIEHS for the research centers program, research and development contracts, and intramural research. At the environmental health science centers, rising costs and stable level of support will force some centers to delay or eliminate research projects in pharmacology, toxicology, and human epidemiology. New targeted research and test development projects important to the objectives of improving the efficacy and speed of chemical toxicology tests will be deferred. The equipping of research laboratories and supporting services at the new NIEHS facilities will be deferred. This will result in delaying research in fields such as molecular genetics, comparative pathology and physiology, which holds promise of improving the nation's capability to identify and control environmental factors that influence human health.

National Institute on Aging

For the NIA, the rescission will slightly delay research progress in such areas as neurosciences, immunology, and nutrition because of the reduction in research project grants. Every effort will be made, however, to maintain a balanced program. Further inclusion of women in the Baltimore Longitudinal Study of Aging will be delayed, making it more difficult to obtain the necessary cohort of study subjects for comparison of age differences in men and women.

Division of Research Resources

The rescission will enable the Division to maintain the most vital portions of its five extramural programs; however, all programs will share in the rescission and operate at a reduced level in 1981. At the rescission level 71 General Clinical Research Centers will be funded -- 4 less than under the continuing resolution; 41 Biotechnology Resource grants will be funded -- 7 less than under the continuing resolution; 2 Biotechnology Research grants will be funded -- 3 less than under the continuing resolution; 45 Laboratory Animal Sciences grants will be funded -- 3 less than under the continuing resolution; 74 Minority Biomedical Support grants will be funded -- 10 less than under the continuing resolution; and 13 research and development contracts will be funded -- 7 less than under the continuing resolution. Also, there will be a reduction in the funds available under the Biomedical Research Support program formula for distribution to eligible institutions.

This proposed rescission will delay some research, since biomedical researchers who would have used the resources not available under the rescission may have to delay their work, unless they can find other support in suitable research environments.

Office of the Director

The proposed rescission for the Office of the Director will impact on the administrative structure supporting research, primarily as a result of reduced funds for personnel services and general operation.

EFFECT OF REDUCTIONS IN MEDICAL SCIENCE TRAINING PROGRAM

Senator SCHMITT. The NIH medical science training program represents a principal Federal effort to deal with the problem of dwindling numbers of doctors engaged in biomedical research. This would be related to the clinical research problem that I referred to earlier. What is the impact of the administration's proposed training cuts on this MSTP program? You may want to supply that for the record also.

Secretary SCHWEIKER. We will supply the detailed information for the record. One of the problems, though, is, and it gets back a little bit to the nursing argument, that we just have a tremendous competition for salaries. That is really more of the problem than the nature of the job itself.

INSUFFICIENT SUPPLY OF CLINICAL RESEARCHERS

Senator SCHMITT. It's my understanding that clinical researchers are in short supply in the private sector, as well as in the Government. The research M.D.'s, not Ph. D.'s.

Secretary SCHWEIKER. Right; but I think it gets back to the problem that even in the private sector physicians in private practice get paid more and can do more than those engaged in research. I think that is part of the problem. In other words, the pay gap between the researcher versus the practitioner or the specialist, whether it is public or private, is great. We will give you an answer for the record.

[The information follows:]

CLINICAL INVESTIGATORS

Question. Last year, we noted that a critical problem existed with regard to the supply of clinical investigators in the United States. Could mechanisms be introduced into this year's training budget to help rectify any shortage? At what costs?

Answer. In response to the subcommittee's request last year, the NIH has prepared a report, "Assuring the Supply of Clinical Investigators," which addresses this subject in detail. The report is being submitted to the committee.

As I mentioned in the report, the NIH does have in place, or under development, several programs that are specifically designed to encourage career development in clinical investigation. Included in this category are the following: the short-term training program for students in health professional schools, which has been in operation for about a year, is designed to offer a 3-month experience to students in order to expose them to the advantages of a research career; the medical scientist training program, considered one of the most effective means of developing and retaining clinical investigators, currently supports over 650 students who will earn the combined M.D./Ph. D. degree; the clinical associates program, which has considerable expansion potential, provides both the training environment and research development support for physicians with clinical specialty qualifications; and the program on special training for clinical investigation, now under development at the NIH, is being designed to provide research training for those already trained to deliver patient care.

Additional funds could be effectively utilized to expand existing programs and to initiate new programs.

KEEPING ABREAST OF BLOCK GRANT LEGISLATION

Senator RUDMAN. I do have to leave now, and I'm sorry to have to leave, because I found your testimony, you know, very interesting. I would just say to you that I hope you will keep us informed about the evolution of the legislation on the block grants. I think that is probably singly the most important broad problem that we must face together in terms of developing a legislative program that will be acceptable.

I expect we may have a great deal of difficulty in the other Chamber on this particular issue, and I have heard that. But I have enjoyed having a chance to exchange ideas with you here today and expect that we will be working with your staff to try to find some solution to some problems, that I perceive as being serious, but I think within the realm of solution.

Thank you.

Secretary SCHWEIKER. Thank you, Senator; we want to make clear, knowing the expertise of the staff here and the committee, that we certainly want to work with you. I'm sure there's some fine tuning, adjusting, and compromising that should take place because of the short time that we had to put together this budget proposal. We would be the first ones to admit that and want to volunteer to work with the Senators and their staff in doing that.

Senator RUDMAN. Thank you, Senator.

NIH TRAINING

Senator SCHMITT. When Dr. Ferguson was out of the country in London, on December 12, he made the following comment: "It is axiomatic research activities must also include the training of scientists. I believe the amount of training now subsidized is the minimum desirable fraction of Federal support for health research."

One of the administration's budget proposals in fiscal year 1981 is, of course, to limit the number of NIH-supported trainees or full-time equivalents to 10,000. A figure of 10,000 is also kept constant for fiscal year 1982. Are any of the training positions to be cut in 1981 associated with existing commitments?

Secretary SCHWEIKER. No.

Senator SCHMITT. There would be relatively little impact with this midyear cut on schools throughout the country which run NIH-supported research training programs?

Secretary SCHWEIKER. That's correct.

Senator SCHMITT. The subcommittee might assume that most of this money was already obligated before the school year. That's why I'm pursuing this in some detail.

Secretary SCHWEIKER. Mr. Chairman, we believe most of the money is obligated in May or June in this particular case.

Senator SCHMITT. It's related to the next academic school year?

Secretary SCHWEIKER. It is forward funded for the next academic school year. Therefore, reductions in funding shouldn't be a problem in this particular instance. There are about 500 fewer slots than proposed in the January budget.

Senator SCHMITT. Right. It is almost impossible to determine at what point you would go below what is the real true minimum number. Dr. Fredrickson presumably has supported the higher number. You won't know whether you went too far down for a long time. I hope that once we get the economy stabilized and recovering, that the administration will recognize that in a number of very important national areas, the supply of engineers and scientists with advanced degree training is totally inadequate to our position in the world, as well as to the long-term needs of our domestic society.

Secretary SCHWEIKER. One of the arguments that I made with the OMB, when we were in the budget process, was that our basic biomedical research program was one of the crucial programs of this decade, in terms of genetic breakthroughs, molecular chemistry, and biomedical engineering. I would hate to see us give up the prominence we have in the field by a significant cutback.

So I strongly agree with your point of view, and I argued that viewpoint in the appeals process and also in the Cabinet meetings. Fortunately, as far as NIH is concerned, I was relatively successful.

Senator SCHMITT. You had to give up some other things to get it; right?

Secretary SCHWEIKER. I sure did.

Senator SCHMITT. You really didn't have their hearts and minds. You had the logic of their pocketbook; right?

Secretary SCHWEIKER. That's the way the budget process works, Mr. Chairman.

Senator SCHMITT. My only point, all joking aside, is unless the administration believes that they've got a manpower problem, in the intelligence services, in the defense services, and in the national economy and research sector in general, it's never going to be solved. I haven't seen any sign that the administration believes there's a manpower problem.

Secretary SCHWEIKER. I hope that whoever our National Science Adviser is, that he can be a focal point, along with our Department, to get this point of view across effectively.

Senator SCHMITT. The fact that we don't have one yet, which has been an agonizing experience, may reflect the same problem, a lack of basic understanding of the role that science, the technology base and the people in the base play in the advancement of this country. This is almost unbelievable, when you look at the kinds of things which have made this country great in the past.

We're going to depend on you to carry that message within your circles, as well as some of us who will be trying to carry it.

Secretary SCHWEIKER. I'll certainly try to work with the chairman and the committee in doing that.

NIH RESEARCH PROJECT GRANTS

Senator SCHMITT. The administration is requesting 4,799 research grants, new research grants, at NIH in fiscal year 1981, and 4,899 in fiscal year 1982. This is below the 5,000 level, which was designed to stabilize new research grants at NIH.

Doesn't this proposal represent a significant backing away from previous commitments to stablize the research grant program at NIH?

Secretary SCHWEIKER. Let me say that we should have a stabilized research grant program. I certainly concur with that fully. As long as we are not going to give NIH the preference that entitlement programs get, then we're going to have to deal with this problem on a less-than-satisfactory basis. I really think the Congress—not particularly this committee, but the Congress—has to address this issue. If we're going to make other program entitlements and not put a priority on this program too, then that's a consequence of a congressional policy—making entitlements of many of these other programs.

Therefore, I think the issue is whether or not the Congress will continue its past practice of making entitlements in certain areas, thereby, treating other areas as second-class citizens. I realize it isn't this committee which deals with that problem, but that's really the heart of the issue. Until we get away from entitling certain programs and not entitling others, I, as a Cabinet officer, do not have the flexibility I would like to be fair and evenhanded in whatever budgetary decisions we must make.

We're going to really have a battle the next time around on NIH, frankly, because of the fact that so many of these other programs are entitlements. When OMB starts to cut again, the entitlement programs are where they find it hardest to cut.

I share the chairman's concern about the level of NIH research grants and part of the problem relates to entitlement programs. We don't have a similar entitlement program for NIH or these grants.

Senator SCHMITT. Is NIH included in the "all other" segment of the pie chart?

Secretary SCHWEIKER. Yes.

Senator SCHMITT. I would like to call to your attention the pie chart again.

The chart illustrates your point, I think, very, very well, in that even though defense and safety net programs are growing, the others are experiencing growth as well.

Secretary SCHWEIKER. And that's exactly the issue on entitlements that you point to. That's really the issue. Congress has to be able to rethink what programs they entitle, how much they entitle, and whether that is a fair way of spending our money.

Just as Senator Hatfield was saying this morning that is a basic policy decision. When you make an entitlement decision, you are mandating that we are going to fund that program, no matter what. We're going to have to rob other programs to do it.

And that's a critical point.

SOCIAL SAFETY NET PROGRAMS

Senator SCHMITT. That's what a safety net program is, an entitlement program. The administration is joining with us, at least in this round, to protect those.

Secretary SCHWEIKER. Let me say one other thing that needs to be said. There are going to be some hard budget cuts in the fiscal years 1983 and 1984. I think a number of us who have gone through this process, including my colleagues in the Cabinet, recognize that if we're going to achieve our goal of a balanced budget, we're going to have to look at the entitlement programs in the next years. We're going to have to look at the defense programs in the next years. In the long run, there shouldn't be any sacred cows in the next budget review process.

That's a personal view, but I think it's also a view of some of our colleagues, and a necessary view if we're going to achieve our goals.

Senator SCHMITT. I agree with you. Even if we break the inertia of inflation and stagnant growth, I don't think we have a choice, because if we don't do what you are suggesting, any improvement we see in the economy will disappear very rapidly. Are you willing to tell me how you argued, with respect to indexing, in general, in the budget discussions.

Secretary SCHWEIKER. I think it's no secret, Mr. Chairman, that the President felt that he had made a strong commitment to the people during the campaign, in terms of this issue. He had made a commitment, to a lot of senior citizens groups, and he felt honor bound to live up to his commitments. As a person who's gone through the campaign route myself, a number of times, I agree with that, because I feel you have to live up to the commitments you have made.

The point I was making a moment ago is that the President did live up to that commitment this year for 1982. I think a situation changes and we certainly are going to have the prerogative of looking at other options in later years. The President has a strong personal feeling about it. That's why we have the safety net in this year's program.

The social safety net programs are not set in concrete and are not locked up for the next 4 years.

Senator SCHMITT. I'm glad to hear that, because as we found with the grain embargo, circumstances do change, and it's not always possible to live up to a specific commitment, even though you're living up to the broad commitment you made.

Secretary SCHWEIKER. Let me also say that one thing I did argue about, and I think the discussion is still underway, is our use of the cost-of-living index. We wonder if it is an accurate reflection of costs, because that becomes the vehicle for indexing entitlement programs. I want to make a distinction between the index, itself, and indexing in social security. We now have underway within the Cabinet a proposal to review the cost-of-living index, itself.

Now that's a different issue from indexing, and I want to make that clear.

IMPACT OF INFLATION ON NIH BUDGET

Senator SCHMITT. We discussed previously the question of inflation, and I don't intend to reopen that, but in assuming that the 9.5 percent is a corrector in the budget, wouldn't that call for an NIH budget of $3.960 billion or $344 million above the 1981 continuing resolution?

Secretary SCHWEIKER. I argued that, Mr. Chairman, but I lost that argument.

Senator SCHMITT. And so just for our record, the Reagan fiscal year 1982 NIH budget provides for an increase of $146 million, that's 4 percent over the fiscal year 1981 continuing resolution.

Secretary SCHWEIKER. I argued that, but I also came to the conclusion that in the nonentitlement program area, this program proportionately was faring better than other nonentitlement programs. As you can see, some of them are getting cut by 25 percent. I accepted the NIH funding level, after the final package was worked out, but I did make that point.

Senator SCHMITT. If the 1981 rescission of $126 million is adopted, the 1982 increase over 1981 grows to $272 million. I don't think the subcommittee would argue that every program has to keep up with inflation, certainly not that, but research programs find it very difficult, if you're going to maintain some kind of a maintenance level of research, it's very difficult not to keep up with inflation.

Secretary SCHWEIKER. Let me amend one point that I didn't make clear from my initial answer. If you apply that percentage increase to the overall NIH program, the answer that I gave you was correct, as I said it. On the other hand, if you look just at the research project grants themselves, for the number of projects that we did propose, we provided for a 10-percent increase for the project grants themselves. The difference in percentage increase occurs because the total figures include things other than project grants.

If you look at the total figures, no, we didn't apply that cost of inflation factor to the other NIH program areas, but we did put into the budget a 10-percent increase for research project grants.

So to some extent, we have an inflation factor built in, but it isn't across the board. That's why the total figures don't come out the way they should.

Senator SCHMITT. With respect to indirect costs associated with research grants, we understand that payment for such costs related to research grants is supposed to average 28.6 percent of the grant. There is concern, however, that for some universities, their share of the grant may go far higher than the standard procedure, that is, their share for indirect costs.

What is your information on this?

Secretary SCHWEIKER. In general, these grants have been growing by less than the CPI for some special reasons. We will supply you with a more detailed explanation for the record. We will show you our calculations and our reasoning.

Senator SCHMITT. NIH has been asked to supply us some specific detail on how the universities are doing with respect to overhead costs, indirect costs, and we haven't received that yet. It would be useful for our deliberations.

[The information follows:]

The response to that report has begun, however, it has not been completed. The completed report will be submitted to the subcommittee staff as soon as it is completed.

FOGARTY INTERNATIONAL CENTER

Senator SCHMITT. I think there is a danger in this particular type of economy that universities may be using more of the grant for overhead costs than we should allow. Some reports indicate that the indirect costs may go up to 60 percent.

Secretary SCHWEIKER. I am informed that we hope to have that information within the next few days for me to transmit to you. Therefore, we should have it to you fairly soon.

Senator SCHMITT. OK, sir. All Departments and Agencies of the Federal Government are being forced to cut back programs and staffing, in the interest of reducing Government spending, yet it appears you have not requested any rescission for the Fogarty International Center at NIH in fiscal year 1981. It appears to be the only major component at NIH that is not hit with a rescission.

Why was that, and what would be the effect of a rescission of some proportions?

Secretary SCHWEIKER. Would you like us to send you a rescission on it?

Senator SCHMITT. You mean you didn't do it, just because you thought you were afraid of the Congress?

Secretary SCHWEIKER. The reason for it, Mr. Chairman, was logical. Unlike the other programs, Fogarty doesn't have the usual program support. What we do foster with the Fogarty Center is an exchange of ideas and technological and scientific advancements between our scientists and foreign scientists. We felt, since many advances are made abroad as well as here we would be short-changing ourselves in the exchange of scientific information and knowledge if a reduction in funding was proposed. Basically, the exchange in the world scientific community would be short-changed. This is the Center's primary function.

We wanted a stable activity; however, we're open to ideas on that. Our thought was that we had spent $3.8 billion for research and ongoing operations, and if we don't exchange information with other countries and they interact with us, we lose some of the benefits of all of our scientific development. We don't learn as much.

Senator SCHMITT. But on the other hand, in this particular point, and hopefully, a temporary point in time, we're cutting back on our ability to gain new scientific information, but we're not cutting as much as or significantly on our exchange of the information we have already gathered. It is a difficult choice, I agree with you.

Secretary SCHWEIKER. Except there are so many applications right now, in genetic engineering and in the DNA area, as a result of our past efforts.

Senator SCHMITT. I'm not sure we want to exchange that.

Secretary SCHWEIKER. To some extent, you lose the tremendous investment you made in the past, if you don't exchange it and develop it in the international scientific community. That was our thinking; but we're not unwilling to consider other ideas.

Senator SCHMITT. If you would provide us with some suggestion of what might be rescinded and what the effect of that will be, it will be helpful.

Secretary SCHWEIKER. One of the problems is, as soon as you start cutting down, you are going to have certain specialties saying you're cutting them in particular. We do not have a big program in the Fogarty Center. It is only one-fifth of 1 percent of the entire NIH budget for dissemination of information through exchanges. If you begin to cut out certain segments, the scientific specialties are going to feel that you are harnessing their science, and therefore you really don't believe in their ability to achieve results. You believe in somebody else; that is one of the problems.

INTERNATIONAL INFORMATION EXCHANGE

Senator SCHMITT. Do you feel confident that they gain as much as we give from these conferences?

Secretary SCHWEIKER. I think we are providing a big proportion of the information in these conferences. Obviously we give more information than comes back. But when you're dealing with people's health and life, isn't that a good foreign aid program? Even if you say we give more than we gain, I'm not sure that some of our help doesn't come back to us just because of international health problems, such as drug abuse, for example. There are other problems we have where we know they are related to situations abroad. I'm not sure that that's totally true. I think it's true in some biomedical areas.

In another area we may gain, because we learn another country is developing a drug ahead of us because of, for example, slow FDA procedures.

DRUG APPROVAL PROCESS

Senator SCHMITT. We really haven't reacted to that kind of knowledge, have we?

Secretary SCHWEIKER. We haven't reacted, you say?

Senator SCHMITT. Yes.

Secretary SCHWEIKER. I know we haven't reacted. I'm able today to announce that we have a new FDA director who, hopefully, will react to that. I think one of his first missions is to respond to that. I selected and recruited him on the basis that he would react to that situation.

Senator SCHMITT. Excellent. That's good to hear.

Secretary SCHWEIKER. Dr. Hays, who is head of the Division of Pharmacology at the Hershey Medical Center at Penn State, is also the outgoing president of the Pharmacology Association of the country. He is a Rhodes Scholar, a very well-known, outstanding expert in pharmacology. He shares my views about expediting our drug approval applications in the early stages when we're testing animals that don't have any health and safety problems. He also shares my view that we can make administrative changes in FDA to shorten the present 7-year cycle of getting a drug on the market.

Senator SCHMITT. Excellent. We'll be looking forward to talking to Dr. Hays. Even though that portion of your budget doesn't come under our jurisdiction, we may have a chat with him anyway.

NIH OFFICE OF THE DIRECTOR

It appears that you have not requested much of a rescission for the Office of Director of NIH in fiscal year 1981. Something like $360,000 out of a $22 million budget. For the time remaining in the current fiscal year, please tell us how much you still can rescind, and what the effect will be.

Secretary SCHWEIKER. We don't have that breakdown here, but we will supply it for the record, Mr. Chairman.

Senator SCHMITT. Thank you.

[The information follows:]

MAY 1981

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

Office of the Director

Effect of House Action - FY 1981 Rescission Request

	1981		
	Currently Available	Rescission Request	House Allowance
Direct operations	$11,878,000	$ -202,000	---
Program management	10,671,000	-158,000	---
Total	$22,549,000	$ -360,000	---

House Action

The House has rejected the proposed rescission of $360,000 and directed that the amount restored be used to partially offset the pay raise costs of $1,047,000, which were requested as a supplemental. The supplemental for pay raise costs was not approved.

ADAMHA RESEARCH

Senator SCHMITT. Mr. Secretary, the subcommittee in the earlier hearings spent a fair amount of time discussing dental care and some of the potential breakthroughs in reducing what was estimated, as I recall, an $8 billion annual cost of dental care to society. I bring that to your attention and encourage you to look at that closely. I am sure you are already looking at that in your preventive health areas, preventive medicine may be a better term than preventive health.

The administration is proposing to include in the self-services block grant, the service components currently positioned in the National Institute of Mental Health, the National Institute of Alcoholism and Alcohol Abuse, and the National Institute of Drug Abuse.

Do you plan to disband the current three Institutes when the service component is moved into the block grant program?

Secretary SCHWEIKER. We have made no decisions in this area. Obviously, these programs will still have a very important research function, and I intend to see that function carried out. We're pretty open-minded on the vehicle to do that. Even though we are reducing funds in the grants to States, I feel that the research component is a very important part of the national health research picture. Therefore, I wouldn't want to do anything that would indicate administratively that we're going to collapse or fold or wipe out these functions, because we're not. We have made no decision about any consolidation or streamlining or reorganization.

We certainly are going to keep the research functions intact one way or another. I emphasize that I feel they are very important, even though the funding for the grants to States has been split off.

Senator SCHMITT. Are you considering putting the research in NIH?

Secretary SCHWEIKER. It's a possibility. I must be candid and say that the research community served by these organizational units would strongly oppose that. I would certainly give a strong consideration to that opposition, because there is a psychological, as well as a biomedical, component to behavioral problems. I think the two have a joint responsibility, so I would consider that as a significant factor. That's why, again, we haven't made any decision on it.

Senator SCHMITT. And the same for the training program in those three Institutes?

Secretary SCHWEIKER. That's right.

Senator SCHMITT. We will certainly work with you on trying to sort that one out.

Secretary SCHWEIKER. We would be glad to have some guidance on it, because it is a complex and sensitive problem. I want to indicate a priority in this area, even though funding has been reduced.

Senator SCHMITT. My suggestion relates to our previous discussion this morning about the type of research that is currently useful in these areas, field versus what is considered more ivory tower academic research. I'm sure there's a fix, because there always has been in other sciences. At this point in the history of these kinds of programs, field research may actually be more important than most of the laboratory research.

Secretary SCHWEIKER. Right.

SOCIAL SCIENCE RESEARCH

Senator SCHMITT. We have had a tremendously difficult time, Mr. Secretary, in this committee through the years in finding some measure of the success of Federal alcohol and drug abuse and mental health programs, some quantitative way, in which, at least on a national scale, we can determine the cost effectiveness of such a program. We know of excellent individual examples of where there seems to be a highly motivated well-run, quite effective program, but national statistics seem to be lacking.

I don't know whether you have anything at this point to add to the committee's deliberations, but we are searching for that kind of information.

Secretary SCHWEIKER. I would share your concern in this area. I think it gets back to the previous discussion in which Senator Hatfield raised the question of social research versus biomedical research. I believe that we have a duty to define more clearly the effectiveness of research in this area and to determine whether or not it is justifiable.

I want to work with the committee on that.

Senator SCHMITT. What is your feeling as to the attitude the Federal Government has toward these types of problems. Do you think we have gotten complacent in recent years, to the point where we now have such a tremendous indirect cost to the Government?

Secretary SCHWEIKER. There's no question, Mr. Chairman, we've gotten complacent. The trouble is, we have seen this day after day. We've seen it in the problem of drunken driving, which accounts for about half of the deaths on our highways. You've also seen it in the area of lung cancer. The tragedy is, we have gotten complacent. What I'm looking for is a way to increase the priority of these programs, whether that results from working with the private sector or from some other method.

SCHEDULING ANOTHER HEARING

Senator SCHMITT. Senator, what is your schedule this afternoon?

Secretary SCHWEIKER. I have a meeting back in my office at about 5 and I have a hearing tomorrow before the Senate Labor and Human Resources Committee at 9.

Senator SCHMITT. We have quite a bit more we would like to cover. Can we work with you on finding another half-day? I think that should be sufficient, another 2½ hours.

Secretary SCHWEIKER. Yes; it would have to be a little later though, not this week.

Senator SCHMITT. No; I don't think it could be, but maybe next week. How does it look?

Secretary SCHWEIKER. We might be able to work something out the latter part of the week. I have a speaking engagement on Monday and a hearing on Tuesday. However, we could work out something later in the week.

Senator SCHMITT. Will you look at Wednesday, maybe?

Secretary SCHWEIKER. We're negotiating for my other hearing now. I'm the most sought-after guy on the Hill, I find out.

Senator SCHMITT. Well, you're an attractive guy. Dynamic, young new Secretary.

Secretary SCHWEIKER. I'm sure of that.

Senator SCHMITT. We do have quite a bit more that we would like to discuss with you. This day has been interrupted by several different things, and we haven't got quite as efficient as we had hoped. So we will work with you on that. We certainly will have questions for the record.

Secretary SCHWEIKER. I will be glad to do that.

Senator SCHMITT. Senator Specter, did you have some questions you wanted to ask?

Senator SPECTER. I just wanted to come by to pay my respects.

Secretary SCHWEIKER. We're glad to have that.

Senator SPECTER. I would have been here this morning, Mr. Secretary, Mr. ex-Senator, but I had my first hearings on juvenile justice, and as we know from long years of experience here what this kind of a day has been like, with the kind of floor activity, although I heard a very excellent presentation briefly over lunch today.

Secretary SCHWEIKER. I appreciate the Senator's coming by. I realize how many conflicting pressures you have. I was remarking to the chairman that when the bells rang, it was the first time I could sit through a ballot and thumb my nose at the bell after 20 years.

Senator SPECTER. It must be very nice. I've heard from some of your colleagues, and one of them, Ms. Townsend, when she appeared here about 2 weeks ago, saying she must have been hired because she was in the same fraternity. You and she are Phi Beta Kappas.

Senator SCHMITT. Well, Mr. Secretary, we will let you go, and we will work with you in scheduling for the continuation of the hearing another time. We will be providing you with some questions for the record in the next day or two. There are some areas that I would certainly like to continue our discussions. I am sure there are some areas the other members of the subcommittee would like to discuss as well.

[CLERK'S NOTE.—At the conclusion of the hearing a number of questions were submitted to the Secretary to be answered for the record. All written questions and answers relating to the two hearings with the Secretary may be found following the April 8, 1981, hearing.]

SUBCOMMITTEE RECESS

Senator SCHMITT. Thank you very much.

We will recess the subcommittee until 9:30 a.m., tomorrow morning, Thursday, when we will be in room S. 126 of the Capitol to hear testimony from Education Secretary Bell.

Thank you.

Secretary SCHWEIKER. Thank you, Mr. Chairman. Thank you, Senator Specter, for coming.

[Whereupon, at 4:05 p.m., Wednesday, April 1, the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, April 2.]

[CLERK'S NOTE.—The April 8, 1981 testimony of the Secretary of the Department of Health and Human Services follows.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

WEDNESDAY, APRIL 8, 1981

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2:05 p.m., in room 1114, of the Everett McKinley Dirksen Senate Office Building, Hon. Arlen Specter presiding.

Present: Senators Schmitt, Andrews, and Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF RICHARD S. SCHWEIKER, SECRETARY

SUBCOMMITTEE PROCEDURE

Senator SPECTER. Good afternoon, ladies and gentlemen. This is a resumption of the subcommittee's hearing which began last Wednesday, April 1, and we welcome back Secretary Schweiker, formerly Senator Schweiker. The subcommittee is very grateful for Senator Schweiker's reappearance here, as he has appeared before our congressional committees on so many occasions as part of his new responsibilities. The committee is grateful for his willingness to return for further questions on the Reagan administration's new budget for fiscal years 1981 and 1982.

Chairman Schmitt could not be here, but is expected to return sometime in midafternoon to take back the chairmanship of the hearings. It is his expectation that the session will be completed this afternoon.

I am a newcomer, as you know, Secretary Schweiker. I succeeded to a very distinguished Senate seat in the U.S. Senate. I am finding the protocol is, at least on some occasions, to use the erudite questions prepared by staff, which are well calculated, very thoughtful, and very pointed. I shall proceed to the questions which have been prepared, in an effort to enable the subcommittee to make its recommendations to the Appropriations Committee as a whole.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SERVICES

The administration is proposing for inclusion in the health services block grant all alcohol, drug abuse, and mental health services now existing in the three Institutes of Alcohol, Drug Abuse, and Mental

Health Administration. It is stated that these programs would then be funded at 75 percent of the current services level for fiscal year 1981.

By current services, do you mean the final fiscal year 1981 level after rescissions, or the 1981 continuing resolution?

Secretary SCHWEIKER. First let me say, Mr. Chairman, I am delighted to see you conduct the hearings. When I decided not to run again, I had a little consternation about giving up Pennsylvania's seat, as I call it, on the Appropriations Committee, figuring that a new Senator certainly would not be entitled and privileged to that quick an entry into the muscle committee of the Senate. But I am just delighted that you are on that committee, and represent continually Pennsylvania's interest also on this committee. So I am pleased to be here responding to your questions and I congratulate you on a very meteoric rise in the committee system, as being chairman pro tem of the subcommittee right now.

Senator SPECTER. Thank you, Mr. Secretary. I should note at this juncture that I selected this committee assignment on the recommendation of my predecessor in the U.S. Senate, who served on this committee, to wit, yourself. But I am not so sure it's the muscle committee anymore, given what the Budget Committee is now doing.

Secretary SCHWEIKER. There is going to be some sparring back and forth, Mr. Chairman.

Let me first say that in answer to your question, our calculations show that the 75 percent does relate to the continuing resolution before rescissions; that probably would be the highest amount.

Senator SPECTER. Would the consolidation then include funding for the drug abuse and alcohol State formula grant program slated for elimination by rescission in fiscal year 1981?

Secretary SCHWEIKER. Yes; it would. The block grant would include those programs, but we do not count the rescissions as part of the reductions. So we are not asking for a double reduction.

BLOCK GRANT SAVINGS

Senator SPECTER. Mr. Secretary, I heard David Stockman say that with the block grant concept and the elimination of much of the regulation, that a 75-percent funding should cover most of the program elements. Do you consider that to be realistically obtainable?

Secretary SCHWEIKER. I think it is realistically attainable, Mr. Chairman, when you consider two factors. One is that there is a tremendous amount of paperwork and redtape, procedures and staffing that is needed to comply with Federal requirements. I know you know in your job, and I have certainly found out in my job, that about one-third of my time was spent arguing with the Federal Agencies and Departments as to whether or not an application or grant or something was meeting the Federal categorical criteria.

I spend a lot of my time doing that, as I am sure you do. It seems to me that we immediately relieve the States and localities of that regulatory burden. But I think the best proof of all is the response from the director of the health department for the State of Missouri, Governor Kit Bond's appointee, Mr. Achter, who is director of health. He said, "one in five" of his employees works to comply with Federal regulations in the more than 40 health programs funded by the Federal Government. He predicted that his office could do a better job with 75 percent of the funds it now gets, if the Federal regulatory mandates were eliminated.

So he makes it very clear that he believes that one out of five of his people today deals with Federal regulations, and that he could meet the same delivery services that he had before the reduction of regulatory requirements.

I do not know if that is true in all cases, Mr. Chairman; I do not want to make any overclaims. But the State of Missouri has done a good job and they are very efficient. They are also quite sensitive to the health programs, so it is somebody with some knowledge and background speaking.

The second part of my answer is because our programs will require new eligibility for services, particularly in the States' welfare areas; it would relieve the States of about $1 billion of present spending, in addition to the Federal Government saving about $1 billion because of fewer regulatory requirements and less people on the eligibility list. The States will be required to spend $1 billion less of taxpayers' money, so that will free up an extra $1 billion that they could use if some of these programs do not quite come up to snuff in terms of filling that reduction gap of 25 percent. I think that, between the 25-percent staffing saved plus the $1 billion, the States should be able to make up for any cutback in services.

Senator SPECTER. One of the programs which is slated for elimination in the current budgeting is in the Justice Department, the Office of Juvenile Justice and Delinquency Prevention. The Justice Department officials have projected that that would come under the block grant approach of your Department.

JUVENILE JUSTICE

Do you think that with all the competing applications which will be made for these block grants, that there is going to be anything left for a program like the juvenile justice one?

Secretary SCHWEIKER. There are two programs that were zero funded in the block grants in our Department—which really are not in our Department, juvenile justice and legal services. All the programs in our blocks have been calculated on the basis of what money was available either through the State formulation grants or money that was spent, on the basis of actual dollars, and that is the figure that is in the resolution.

We took 75 percent of that figure. There are no funds in the dollar figures that we have made for the juvenile justice program. Even though there is probably legal authority to do a number of those programs under some other section or title of the law, there are not separate funds in the blocks for that.

Senator SPECTER. So if any funds should be available, it would be just what would be done on the State or local level in the use of funds from HHS generally.

Secretary SCHWEIKER. Yes; it obviously would have to be taken out of some other account within the block. I say account, but I mean it would have to come out of somebody else's allocation in the block.

LEGAL SERVICES

Senator SPECTER. You referred, Mr. Secretary, to legal services. Community legal services, was that what you referred to?

Secretary SCHWEIKER. Legal services, of course, did not come in our Department either. But as I understand it, they have done basically the same thing with legal services, so that we probably do have some statutory authority under title XX, and under the Community Services Administration which has been put in our block. So we have statutory authority in the block, but again, we do not have funding that has been allocated to the block for that specific purpose.

Senator SPECTER. Will the block grants go to the States in a lump sum—a block, as the expression goes; and then will it be up to the States to make the decision as to which program is to receive the funds? Whether it is the health program or the juvenile justice program in the community?

Secretary SCHWEIKER. It will go to the States, but it will go in the form of four blocks. In other words, for the program to deal with my Department, they will get four different figures from their State, as to the money they are entitled to spend within a block. They have to spend the money within the block on the 10 or 12 items within that block, so they will get four figures. But those figures will apply only to each block.

Does that answer your question?

HHS BLOCK GRANTS

Senator SPECTER. Yes; what are those four block areas?

Secretary SCHWEIKER. There are two health blocks: One is called basic health services, that has about 8 or 10 different programs; the other is called preventive health services, that probably has about 8 health programs. Another block is social services, which at the present time has 20 programs and is one of the few block grants we have going. The fourth block is the energy block for low-income energy assistance.

So a State will get *x* amount of dollars for each of those four blocks, and can spend it within those blocks. Juvenile justice and the legal services would be in the social services block. That is theoretically where the money could be spent. There is no DHHS money in the block for either of those programs.

Senator SPECTER. Could the State or local government use the money for legal services?

Secretary SCHWEIKER. There is no money for those programs, but they could spend it simply because the statutory authority under title XX and under the community services program do provide for that kind of service now if the State or locality wants to use them.

MENTAL HEALTH SYSTEMS ACT

Senator SPECTER. Last year, Mr. Secretary, as you know, Congress enacted the Mental Health Systems Act which authorized several new project grants to support mental health problems: the chronically mentally ill, severely disturbed, minorities, elderly. These groups were targeted, in large part, because they had been so neglected by mental health programs in the past.

To what extent, if at all, will the health services block grant proposal include any provision to insure that the needs of these special groups will be addressed by the States?

Secretary SCHWEIKER. Under the proposal there is a requirement that before the money is spent, each State authority must inform the legislature and me, as Secretary, how it intends to spend the money within that block. In essence, each State has to put all the interested parties on notice that this is the money, and how it is going to be spent. So programs within each State will have a procedure whereby if they do not agree with their State's plan, they can work with their State authorities to have it changed.

Therefore, each State must publish ahead of time how the money is intended to be spent. No. 2, after the money is spent, they must then account for it to the Federal Government in terms of where it was spent. No. 3, they must get an audit to determine that funds have been spent that way, the GAO may also review it, and I may review it too. In addition, I can use my Inspector General or policy evaluation team, to see if, in fact, they did spend it the way they either were legally required to or the way they purported to do it. So that is the mechanism that is built into the law.

Senator SPECTER. Within that broad area, though, do you have the authority, as Secretary, to disagree with their allocation?

Secretary SCHWEIKER. No; all I have to do is determine that they spend it legitimately within a specific block. The State would make a decision, for example, does mental health get funded at the same level as it was before? Or does some other priority come in, or does mental health get more funding than it did before? So the State has the sole discretion. I do not participate in that decision at all.

Senator SPECTER. Of course, you, as Secretary, would have the understanding that no private groups would do it, as well?

Secretary SCHWEIKER. They would have no standing, except the political process of the State. That is right.

Senator SPECTER. But ultimately, if the State government disagrees with what a private group may suggest, the State group is determined to carry it out as they have predetermined, as long as it is within the broad categories you've described? It is strictly a matter for State discretion?

Secretary SCHWEIKER. That is correct.

Senator SPECTER. Then in the final analysis, if the State left out, say, the chronically mentally ill, or some minority group which hadn't been accommodated by the legislation in the Mental Health Systems Act, that would simply be their decision, which would stand?

Secretary SCHWEIKER. That is correct.

Senator SPECTER. We've been joined by Senator Andrews, the junior Senator from North Dakota. Would you care to ask any questions at this time?

Senator ANDREWS. I would. I appreciate that very much, Mr. Chairman.

Mr. Secretary, it's always good to sit on this side of the table and welcome an old friend and long-time colleague who has grown in fame and stature, and who is doing so much for our country. I have a couple

of questions that concern me. I have asked them of others in your sh
at least one of them I have asked.

COORDINATED AMBULATORY REHABILITATION EVALUATION SERVICE (CARES) PROGRAM

We have a program called CARES. Like so much governmentese in the Government, it is the coordinated ambulatory rehabilitation evaluation service. It is an excellent outreach program in my State, but it is funded by the Health Services Administration, part of the primary care, research, and demonstration program. This is one of those categories that are being cut back right now and are going to be funded at the States' discretion, I would hope.

Under block grant legislation the money comes through at 75 percent of what we've been having. It's been going for about a year now.

Mr. Secretary, the thing that concerns me about this particular program is that so many statistics show that we now have an ample supply of doctors in this country, that we now have an ample supply of nurses, although that statistic is becoming more and more subject to correction. The one thing that we do not have is adequate medical care in chronically underserved, rural areas of the country. And this CARES program is unique among the many that were funded under this arm, because we are an agricultural State. I think we took a page out of the agriculture extension service, and we are taking the technique that exists in the big city hospitals, the big city hospital in this case being Grand Forks, N. Dak. The rehabilitation center is run jointly by our State university medical school and by some State funds. We are taking three or four doctors every month a distance of 400 miles into a six-county area, that is chronically underserved.

There these doctors, who are rehabilitation experts, work with the local general practitioners. Many communities do not have a doctor at all, much less the specific type of ability to take care of the chronically disabled and people who need rehabilitation following stroke, and a number of other things.

What can be expected of a program like this? Do you feel that the transfer of this type of primary care program to a block grant puts adequate emphasis on the need of these medically underserved areas, and isn't it being penny wise and pound foolish, to restate an old and hackneyed phrase? I think, and I think it can be proved, that it will cost the Federal Government two to three times as much if the patients in this rural outreach area have to be moved 400 miles to get this kind of treatment in the medical center rehabilitation hospital, rather than be served in their own areas.

What type of study have you done on this, and what type of answers could you give us as to where emphasis ought to be put?

While I am speaking about a specific program, I am really trying to address the whole challenge that faces us of rural areas being continually underserved medically. And if many of those patients want to get private care they can do so under other Federal programs. But it costs a whale of a lot more to support somebody in a hospital environment 300 miles away from their home, when you can get it by extending the service through a team of doctors moving out once a month to consult with and look at and work with local doctors.

Secretary SCHWEIKER. I would say, Senator Andrews, this is a good program. We would hope that this is the kind of program that would lend itself and would become affiliated with our area health education center (AHEC). In other words, an AHEC legitimately could pick up and carry on this type of work, particularly the training component, which is critical in the rural areas. We would hope that the AHEC center would take it as an ongoing program.

In addition, we also hope that the component of actual service delivery could be picked up as part of a block program. So the training program could be carried on by the AHEC, which is designed to do this kind of thing, and the service delivery could be included within the block grant proposals.

There are at least two ways to continue to provide that service.

Senator ANDREWS. That's the most responsive answer I've had in a long time. We started out with this program when I was still a member of the other body. Our mutual good friend and long-time colleague, Bill Natcher, had his people take a look at this, and they said this particular program that I mentioned in North Dakota was really the star among all of these that are in that category, and they'd like to find some place to transfer them to, because it is a unique type of program.

Could you provide—and I'm sure my chairman, who has the same problems in his State, would be interested—could you provide for the committee, perhaps, a little more detailed explanation as to just what course we could follow in this? I do not want to stress it too much from the standpoint of a parochial issue, although it is one. It's one—when we're looking for new concepts with this new administration, it's important that we not forget the chronically underserved rural areas in this country. Your suggestion is that they could come under a training program where teams of physicians that are trained in a unique specialty go out and work with general practitioners in the rural areas. That would be one of the great ways of not only giving better service to the patient, but saving money for the Federal Government.

AHEC PROGRAM

Secretary SCHWEIKER. I think in addition, Senator, it really will, I would think, command a very high priority in an AHEC in your area. The needs are there in terms of rural delivery and also because the training component is one of the strongest components of the AHEC. We believe that there would be a lot of logic and justification in doing that. We are certainly willing to help in that respect. I think these are the kinds of things the Government has to be sophisticated and selective in doing. When we have a good program, when we know it is directed toward primary care or rural delivery, which I happen to rate a high priority, these are the things we ought to achieve. So I am certain this would be very helpful and I believe there is a mechanism there.

Senator ANDREWS. And the AHEC program is not going to be sliding into this block grant concept?

Secretary SCHWEIKER. I should say, we have not submitted it yet. But I am not letting anything out of the bag when I say that we are preparing a health professions proposal that will include the AHEC program as an ongoing Federal program.

Senator ANDREWS. Then this type of project could be funded in part out of AHEC and in part out of what would then become a block grant fund for North Dakota; the 75-percent block grant funds would handle that part of it, and the other part would be handled by AHEC.

Secretary SCHWEIKER. Exactly, and I would think that from my knowledge it would get a very high priority at the AHEC location, because of the need that it serves for that particular area.

ELDERLY NUTRITION PROGRAMS

Senator ANDREWS. We have another problem. In the years that I have served on the Agricultural Appropriations Subcommittee in the House, I worked to help develop programs that the Agriculture Department sponsored, nutrition and feeding programs for the elderly. For next year, I see that the elderly feeding program in the Department of Agriculture is proposed to be moved over to Health and Human Services, to be included with other nutrition services funded by the State and communities block grant.

Is this the first step in trying to transfer other food programs now run by the Department of Agriculture to HHS?

Secretary SCHWEIKER. I think it is important to make a distinction here, Senator Andrews. This is not the block grant approach. It is something different; we are consolidating it within a national program. In other words, we will not be block-granting.

You are right about the move, but our proposal, which we are working on still, will not move it into the block grant category. It will be a national program. The only thing is that that component will probably come to our Department, if the proposal goes through in its present form. We will place it with three or four similar programs to be consolidated as one Federal program in my Department.

Senator ANDREWS. So the nutrition programs will then continue to be freestanding individual programs that are administered on a national basis?

Secretary SCHWEIKER. That is correct.

Senator ANDREWS. Mr. Secretary, yesterday our subcommittee had the chance to hear Secretary of Labor Donovan testify on the budget proposals of the Department of Labor.

INDIAN RESERVATION PROGRAMS

At that time, I questioned him about the concerns of my constituents on North Dakota's Indian reservations relating to the cutbacks in CETA. On one reservation, the Standing Rock Sioux, they estimate that the loss of CETA jobs on the reservation will increase unemployment there by at least 20 percent over the present unemployment rate of—get this—68 percent. Now, on Indian reservations, we have a specific problem, a rather unique problem.

And when you talk of phasing out CETA jobs, and relying on the private sector to pick up these CETA people, there's a good deal of merit to that in many areas of this country. But where there is no private sector—and on a rural Indian reservation there is no private sector—granted, we're trying to bring some in.

We have a longstanding and very successful venture by the Government called the William Langer Jewel Bearing Plant, a Government plant leased out to Bulova, employing native Americans. The trouble is now, we have more jewel bearings than we know what to do with. We'll have to find something else to do. On another reservation, we have encouraged another manufacturer to move in and make camouflage nets.

On the Standing Rock Reservation, there are no plants such as this. CETA has provided somewhat of a halfway house to get the native Americans off welfare, onto a program where they could work in the tribal council, they could work as paramedics, they could work in the law enforcement field, and a host of other things. It's not the best solution, but it's a whale of a lot better than keeping them on welfare.

Could we find, or could you turn some of your people loose in trying to come up with some type of fallback position so that we don't revert from CETA to strict welfare? Can we do something on these Indian reservations to continue pride in a job, which is so darned important to these native Americans?

Secretary SCHWEIKER. First, let me say that the basic Indian programs in our Department are not going to be block-granted.

Senator ANDREWS. A lot of this is BIA, too, but the CETA program isn't.

Secretary SCHWEIKER. No; but I am saying that some of these other programs, either welfare, assistance, support, or health, are not going to be block-granted. We felt in block-granting them we would possibly affect adversely the Indian community, for many different reasons.

So we are in the process of proposing continuing categorical programs for the Indian community for the bulk of programs that affect Indians in our Department. So, for the Indian programs in my Department, basically, they will not be part of the block grant programs. We are providing protection to the Indian community, because we feel where we have primarily Indian programs, we have a treaty obligation and we are not block-granting those programs.

Now, that doesn't answer your question on the CETA. But CETA doesn't come under us. All I can say is that programs that do come under us will have a high degree of protection.

Senator ANDREWS. But you're looking at ultimate proposals to assist these people who lose their CETA jobs.

Secretary SCHWEIKER. The assistance proposals for Indians will not be block-granted.

PSRO PROGRAM

Senator ANDREWS. I have one final question that has to do with the phaseout of the professional standards review organization, the PSRO's. A view, of course, of more competition in the health care industry is the reason given for the administration's phaseout of the PSRO's. No one can find fault with that broadly stated goal; however, I'm told that—by the doctors in my State—that peer review seems to be the most effective means they've ever used to monitor health care cost.

The competition is fine in urban areas, where there are three or four different hospitals to go to. But in an area like mine, where many counties have but one doctor, much less one hospital, there is no competition. I would imagine there are no more than five cities in my State that have more than one hospital, and most of our hospitals are the only ones in operation for over a 50-mile radius. So, when somebody becomes ill, they don't have much choice, and the competitive factor the administration is cranking in as justification for eliminating the PSRO, again, doesn't exist in a rural area.

What proposal does HHS have for monitoring health care costs for rural areas like North Dakota, where there simply isn't this competition for medical service in so many of our counties and small towns?

Secretary SCHWEIKER. I think there are going to be several aspects that we are considering. We are going to give consumers a choice of, probably three different plans to pick from. We believe the very fact that consumers have a choice will tend to make elements of a community more competitive than they have been up until now—because all it has been up to now is somebody saying, "You're the sole supplier." The company says that, or the medicaid provider says that, or whatever. So there is no competition in rural areas. We are now in a climate where we believe there will be significant competition, particularly in the areas that are not as remote as you are talking about.

By the same token, they will certainly begin to set new standards in terms of costs, cost comparisons, and delivery efficiencies that we believe will either have some spinoff in the rural areas or will be used as an overall standard.

I think another factor will be that we are going to emphasize as much as we can HMO participation, and to waive some of the more stringent requirements on HMO's.

Senator ANDREWS. PSRO's?

Secretary SCHWEIKER. The HMO's. On the PSRO's, we are going to provide a reimbursement mechanism so that a PSRO that can make its way, can show that it is saving money by the PSRO process, will be able to be deducted to that particular service delivery unit, and we would recognize that as a legitimate service, and therefore a charge. Therefore, instead of a Federal pump-priming for PSRO's, we are going to provide for those that pay their way and do their job, reimbursement in the regular delivery system.

For those who can show they save money—and some of them can—they will be able to get business on the basis that they can save the delivery system money that they have been using, and it will be a deductible and reimbursable expense under our proposal. We hope to incorporate them as a way of life in the mainstream, financially, rather than prime the pump the other way, where some work and some do not.

Senator ANDREWS. But your people are aware, as you are, of the unique difference in the need for PSRO's between Philadelphia, say, and Mapleton.

Secretary SCHWEIKER. I recognize that, Senator. That is why I say we are going to have to use some different approaches when it comes to the purely rural areas. I think we also may want to look even closer than we have at something such as physicians' assistants and nurse practitioners, as a way of giving rural areas some improved or at least regular service.

We made a change, as you know, a few years ago in the reimbursement mechanism to provide that we can give—where we could only reimburse a doctor before, now we can reimburse nurse practitioners. I think that is the kind of thing we can do.

Senator ANDREWS. But we still need the yardstick to measure how the doctor is performing. We have a doctor in one small town who is charging twice as much, say, as the doctor in a small town 100 miles away.

Without a PSRO, there's no way to regulate that. The person who happens to live close to the doctor that's overcharging is simply stuck, because he doesn't have an alternative.

Another problem that adds to those is the fact that you've put manpower ceilings in your National Health Service Corps that cut down sharply on the availability of Corps doctors for medically underserved areas. Let me point out how that works.

One town in my State recently applied for a Health Service Corps doctor. Without a doctor, the town is afraid it's going to have to close down its small hospital. Obviously, you don't need a hospital if you don't have a doctor. Their application was quickly approved for a Health Service Corps doctor, and it was designated as a manpower shortage area for doctors. But they've just been told by the Denver office that while they've been approved, they're going to have to wait between 1 year to 18 months to get a doctor.

Now, this length of wait for getting a Corps doctor is not unusual, I'm told, because there aren't enough doctors in the Corps to go around. Now, since you've put manpower ceilings on, the region is having to reduce its number of doctors by 22, from 90 to 68. That means if a Corps doctor was found to go into the town, someone else from somewhere else in the region would have to go.

How does the administration propose to address the needs of these medically underserved areas with a reduced force of National Health Service Corps doctors? Are we simply going to tell the good people of Wishek, N. Dak.—which, incidentally, is one of the most Republican areas in the Nation; I think they voted 85 or 95 percent for Mr. Reagan—that they can't have an appendectomy for 18 months, because it's going to take that long to get one of these doctors assigned?

NHSC PROGRAM

Secretary SCHWEIKER. First of all, in the National Health Service Corps, you should understand that the budget that I have proposed for 1982 shows a 500-slot increase over 1980.

We have not cut the absolute numbers of Service Corps field people.

Senator ANDREWS. Then somebody's told us the wrong thing, because they've told us that the number of Corps doctors are going to be cut down, and—in the Denver region, from 90 to 68, by September 30 of this year.

Secretary SCHWEIKER. Let me explain why somebody gave you the wrong information. The Carter budget proposed to take the 2,000 doctors and increase them to 2,900. We did not do that. We are recommending that the 2,000 doctors be increased to 2,500. So we cut a program that never existed, but we increased the current program by 25 percent.

I think you have to understand what the difference is. The answer they gave you was not accurate, because we are increasing the base 2,000 number by 500 slots over what we now have.

Senator ANDREWS. You're increasing by 25 percent. So you're going from 90 to roughly 110, instead of from 90 to 68?

Secretary SCHWEIKER. Nationally, that is the figure. I do not know how it breaks down in your area.

Senator ANDREWS. I would hope you're putting at least as much emphasis on the underserved rural areas——

Secretary SCHWEIKER. We are, and I'd be glad to run down that particular case that you are talking about, because I have trouble reconciling that with our figures. I would be glad to pursue that figure for the record.

[The information follows:]

NATIONAL HEALTH SERVICE CORPS—NHSC—REGION VIII ASSIGNMENTS

Of the 95 NHSC positions allocated to region VIII in fiscal year 1980, 3 positions are in North Dakota—2 physicians, 1 nutritionist.

Of the 68 NHSC positions allocated to region VIII in fiscal year 1981, 1 position is to be assigned in North Dakota—a physician.

There have been no regional allocations of NHSC positions for fiscal year 1982. A total of 2,500 assignees will be available for assignment.

MEDICAL DELIVERY SYSTEMS

Senator ANDREWS. Thank you, Mr. Secretary, and I appreciate the indulgence of my chairman. It's great to greet an old friend on the other side of the table. I appreciate the cooperation we've gotten from you and your Department.

I'm glad to ascertain today the feeling that you have for the unique medical delivery system problems we have in our rural, very thinly populated areas. My grandparents came out to Mapleton in Dakota Territory, and they were both doctors, and they retired. My grandfather died in 1904. My grandmother quit practicing medicine—they practiced in New York City for 2 years and came out to Dakota Territory 3 years after Custer got clobbered in the Battle of Little Bighorn. When they ceased practicing medicine in Mapleton in 1904, that was the last doctor that the town of Mapleton has had. That's true, I think, all over areas like North Dakota, and New Mexico, I'm sure, is the same way. When they were first settled, they had doctors from the top medical schools in this country. My grandparents happened to go to Michigan. And we simply don't have them anymore.

With your help and your understanding, I think we could turn this around and do justice to the health care needs of rural areas.

Secretary SCHWEIKER. I certainly concur that whatever cutbacks and reductions we make, we have got to do them in a way that does not discriminate against rural areas. I have a strong feeling about that. As Senator Specter would know, Pennsylvania has the largest rural population of any State in the Union, so we are pretty sensitive too, even though people identify us with the Northeastern industrial States. So I certainly will pay close attention to it. I will, as I mentioned, follow up that case you gave us there to see exactly how they arrived at those figures.

Senator ANDREWS. I hope you would. I'll be looking forward to hearing from somebody in your shop as to the more accurate figures.

Thank you.

RURAL HEALTH PROBLEMS

Senator SCHMITT [presiding]. Thank you, Senator.

Mr. Secretary, relative to the rural health problem, I'd like to provide you with a copy of an editorial that appeared in the Albuquerque Journal on February 15. The unfortunate heading reads as follows: "Reaganomics Could Doom Rural Health Care in New Mexico." I think it summarizes, at least, part of the perception that your program has. You have not yet been able to clarify how the various portions of the proposals you are considering interrelate, so that in fact, rural health care may not be doomed. As I understand it, you have indicated that it will actually improve. We'll provide you a copy of the editorial, and I would appreciate if your staff would provide us with the rebuttal.

Secretary SCHWEIKER. We would like to have the specifics in order to respond adequately.

Senator SCHMITT. I hope that the problem is a misunderstanding based on a set of assumptions and incomplete information. It may indicate the degree to which you have a selling job to do out there, that what you're doing is not, in fact, going to doom rural health care.

The man who has written this editorial, Eric McCrossen, is not exactly unknowledgeable about these issues in New Mexico. We'll provide you with a copy of the editorial. I'd appreciate some comments for our record. The record will also include a copy of the editorial.

[The information follows:]

[Albuquerque Journal (N. Mex.), Feb. 15, 1981]

REAGANOMICS COULD DOOM RURAL HEALTH CARE IN NEW MEXICO

(By Eric McCrossen)

Reaganomics could deal medical care in rural New Mexico a devastating setback unless Congress or the legislature acts.

Closed rural clinics. Very few physicians, nurses, or paraprofessionals. Long trips to the city for even the most basic medical or dental care. That's the grim scenario being painted by experts preparing to fight to protect gains made in rural medical care during the past decade.

Two impending decisions by Richard S. Schweiker, Secretary of Health and Human Services, threaten programs that have encouraged health professionals to practice in rural areas.

Schweiker wants to cut the Federal health services budget 25 percent. He also wants to replace categorical grants with block grants which the States would distribute.

A program that has worked exceptionally well in providing rural New Mexicans with health care is threatened. The National Health Service Corps is a scholarship program that provides a pool of health care specialists for rural America. In exchange for Federal loans to attend medical school, students contract to serve for at least 2 years after graduation in rural areas. Approximately 50 health care specialists are fulfilling such contracts in New Mexico rural areas.

The Federal Government provides about $8 million a year for health care programs in the State. Another $4 million is generated through fees collected at 48 practice sites throughout New Mexico.

David Goldberg, executive director of New Mexico Health Resources, believes the proposed Federal budget cuts could be devastating on medical care in the State's rural areas. Approximately 100,000 residents are served at less than $140 per person per year, he said.

The 25-percent cut for each of the next 3 years will have an even greater negative impact, Goldberg believes. The present categorical grants are serviced by regional offices. With block grants made directly to the States, each State probably will establish a specialized bureaucracy to distribute and monitor grant money. That will further reduce the money available for health care. The headaches will be real, too. Each program that now receives categorical grants from the Federal Treasury can be expected to fight for grants for its own constituency.

Last week at the National Conference on Rural Primary Care in Denver, U.S. Senator Patrick Leahy, D.-Vt., warned that the Reagan administration's budget cutting proposals could be disastrous for many rural health care programs if block grants that are part of the budget package are allocated on a population basis.

New Mexico Senator Harrison Schmitt also addressed the conference. He said that planned Federal budget cuts would not harm rural health care programs if they are handled properly.

"There are many who are looking forward to the future as a threat," Schmitt said. "But, with your help we will create a better system * * * Rural health care and all the other things will suffer if there isn't economic recovery."

More than 50 New Mexicans attending the Denver conference heard discussions of a legislation draft that would change categorical grants into block health care grants. The speed with which the legislation came down, Goldberg said, "is unprecedented."

New Mexico faces a peculiar problem in adjusting to the change in funding since the legislature will not be in session when the cuts are determined. The timing of the proposal has left no time for the State to develop alternative plans for continuing basic rural health care services.

Ironically, a House bill that might help the State prepare to meet the problem is awaiting legislative action. The rural primary health care act is designed to recruit and retain health care personnel in underserved areas of the State.

The bill would appropriate $200,000 for the health and environmental department to contract with a State nonprofit corporation.

There is concern that the State could lose even more Federal support if it doesn't take positive steps to support the rural health care program itself. New Mexico's multimillion dollar revenue surpluses generate little sympathy in Congress. The Reagan administration's budget philosophy is aimed toward greater local control and participation in social programs. Rural health care could become one of the victims of that philosophy if the State doesn't spend some of its own revenue in support of such programs.

The President's program for economic recovery includes certain fundamental policy changes. A major change in health care is the proposed consolidation for fiscal year 1982 of a number of specific categorical programs into broad purpose block grants to States. The block grant proposal is intended to provide the States with flexibility so that they may identify priority concerns and rationally plan for and allocate resources in accord with those concerns.

Most categorical activities supporting primary health care such as community health centers and migrant health projects are included in these proposals. Also included are maternal and child health, family planning, mental health, and various other categorical programs. However, the National Health Service Corps which provides health manpower for the most critically needy areas is not proposed to become a part of the block grants. In addition, the President's budget for fiscal year 1982 proposes to increase funding and to expand the number of field assignees for the National Health Service Corps compared to current levels.

The total funds to be received by the States will be about 25 percent less than was made available through the categorical grants; however, States are expected to make substantial savings through administrative efficiencies and coordination efforts.

Whether or not New Mexico's rural primary care efforts are reduced in support depends on the State official's decisions on priorities and funding provided to address these State priorities. The following represents New Mexico's percentage of total current Federal categorical program funds, and its current funding levels, for programs to be consolidated into health block grants, and estimated block grant allocations for New Mexico under both the health services and preventive health block grants.

	Percentage of total current program funding	Current program level	Estimated block grant funding levels
Health services block grant	1,237	$17,879,833	$14,069,630
Preventive health block grant	1,065	$3,513,387	$2,577,288

PSRO PROGRAM

Senator SCHMITT. I'm also interested in what you said about PSRO's. It sounded at first blush, that you might have hit on a scheme that would preserve a working and effective PSRO and encourage others that are not viable to adopt better management and implementation schemes. I'm sure that's your objective.

Secretary SCHWEIKER. That is my objective.

Senator SCHMITT. I'll be very interested to see the details of that proposal.

Secretary SCHWEIKER. That is my objective, Mr. Chairman. I think that if we can do as I hope we can, we will solve two problems. If PSRO's can legitimately justify their existence in terms of either quality, price, or whatever, then it ought to be viable in the economic system, and we should reimburse them. If they are not viable, we shouldn't be subsidizing or even supporting them. Which gets back to the argument we're having today—some of them are viable, some of them are not. We really do not want to subsidize both kinds. We want to subsidize or support—a better word—the ones which are viable. That is why we're interested in incorporating their feature in our proposal.

Senator SCHMITT. That will be good news, at least to the New Mexico PSRO's, where they have a very strong benefit/cost ratio, at least as I understand it.

Secretary SCHWEIKER. A lot of them do, and I acknowledge that. That is why we ought to be able to take advantage of that and put it into the reimbursement in a way that makes it beneficial.

Senator SCHMITT. Have you ever given any thought to applying the same kind of approach to the health planning agencies?

Secretary SCHWEIKER. I have, Mr. Chairman. It's a little harder to do with a PSRO. I think they can conclusively make a case that they're either paying their way and saving money, or they are not. That is pretty easy to measure, in an accounting sense.

When you get to health planning, I don't see the same handle. If I could be shown a handle, a way of getting to grips with that, I certainly would consider it. To date, I have abandoned several alternatives on the basis that I do not quite see how you can calculate what a health planning group does or actually costs or saves in view of the many variables in communities and because of their many facets.

But, if there is some easy way, either realistic or practical, I would consider those too.

MEDICAL FACILITY CONSTRUCTION

Senator SCHMITT. I've been convinced that, at least in New Mexico, the health planning agency, in contrast to the State agency, which has some other difficulties, has been able to actually prevent the construction of unnecessary capacity.

If you can explore some way to measure existing capacity and existing need to determine whether the optimum ratio is maintained by a particular health systems agency over the area it serves, or whether it's lost, it will be very helpful.

Surely there is some way that we can examine that, because I'm convinced, at least on a theoretical basis, that a well-run health systems agency which reaches out and involves communities, rather than just sitting in the State capital can, in fact, provide a cost-effective way of planning health facilities.

Secretary SCHWEIKER. We're willing to look at that.

HEALTH CARE CHOICES

Senator SCHMITT. We'll try to get with you, if we can, to explore some suggestions and establish some dialog on that.

I have one general question before we both have to go vote and leave you for about 10 minutes. It's been said that health care cannot be considered a legitimate component of the free enterprise system for the simple reason that the consumer is not a consumer of choice. When the consumer needs health care he has to get it, but he doesn't want it, unlike almost all other aspects of the free enterprise system where one is trying to get the consumer to desire a product. The consumer, unless he's a hypochondriac, is never going to "desire" medical care.

Do you agree with that thesis, and is it right to assume that it negates the free enterprise system?

Secretary SCHWEIKER. I agree that the health delivery system is a somewhat unique function that does not fit into our present definition of the way our basic economic system operates, but I believe that you can even get a competitive factor existing in the health field if you do some things in the infrastructure and institution that we do not have to do in other fields.

So one of our proposals that we'll probably give top consideration to will be a proposal that would give a consumer a choice between three basic plans of health care. One would be an HMO, one would be a conventional plan of some kind, insurance or whatnot, and the third would be a plan that has high deductibles, no first dollar coverage and some copayment features.

The idea would be that the companies involved would have to make an equal contribution to all three so that employees could use any one. If an employee picked the one that had the lowest cost, the employer would receive a rebate of some kind. You'd give employers an incentive to self-insure, much like the person who buys a $200-deductible insurance policy on a car. By giving consumers that choice, whether HMO, the deductible copayment route, a reimbursement portion or the conventional system, we believe will force a discipline of the marketplace and competition that does not currently exist.

Senator SCHMITT. I hope you're right. I think we've got to approach this cautiously, because of the basic difference between health care consumption and other types of consumption.

HMO'S

Secretary SCHWEIKER. In addition, Mr. Chairman, if you have the HMO, unlike some of the other delivery systems, it in essence makes a profit if you stay well, while the problem with the other system is that they make money if you're sick. That is one of the reasons we are in a bit of trouble. Whereas with the prepaid group plan concept there is a cost incentive to keep a person well and keep them out of the hospital.

So I believe we can build some honest incentives in the system that are not there now, utilizing some different and creative features.

Senator SCHMITT. The unfortunate thing is that some HMO's have had a hard time developing the management structure, so that they can become viable and self-supporting.

Secretary SCHWEIKER. You'll be glad to hear that I just addressed a class of 35 HMO managers who graduated from my Department today, after spending a year in training, who will go out in the field, as part of an amendment that I put into the bill about 2 years ago. So we are beginning to graduate qualified managers. You're right; there's been a shortage, and that also will be in the new HMO bill that we'll continue to send up. But I just graduated some 35 from my Department about 15 minutes ago.

Senator SCHMITT. We will recess for approximately 10 minutes while we vote?

Would you like to join us? [Laughter.]

Secretary SCHWEIKER. I'll join you for the recess.

Senator SCHMITT. Mr. Secretary, check with your staff and see if they're aware of the rural primary health curriculum that's been developed at the University of New Mexico. I was wondering if you're looking at that kind of thing as another part of the rural health care delivery system.

[A brief recess was taken.]

RURAL HEALTH CARE

Senator SCHMITT. Mr. Secretary, I don't need a long answer. I just call your attention to the New Mexico plan which has now been in effect in an experimental way for a couple of years and seems to be working successfully. We have a separate type of medical curriculum for rural primary care, looking to not only find people who initially volunteer for that type of health delivery, but also in the course of the study learn the rewards of that type of health delivery.

I think if we encourage that kind of development in other institutions around the country, particularly those that are associated with rural portions of the country, that we may further reinforce the kind of plan that you have in mind.

Secretary SCHWEIKER. I certainly concur, Mr. Chairman. I think this is the kind of program that we do want to foster and engender and also get other areas to use as a model of what to do.

Senator SCHMITT. I think there's been some improvement. I do know that for a long time in trying to recruit medical personnel for rural situations, there was modest success in most specialized disciplines, except for internists, although I think there's been some improvement in that area. I think it does reflect that there was a fairly set way in which we trained our doctors and other health providers. It was more associated with the city hospital environment, that they would offer research institution style environments which bore no relationship to the kind of environment that existed in rural areas.

Once the person is through that kind of training, it's sometimes difficult to turn your back on all the research opportunities, discussion opportunities, and other things like that and go back into a rural environment, where if you're not in a parallel system of training, parity can be more successful in orienting new students to that activity.

NATIONAL COMMISSION ON ALCOHOLISM

Mr. Secretary, recently the committee received a reprograming request of $500,000 to begin activities of the National Commission on Alcoholism. Specifically, what is this Commission proposing to do that cannot be done within your Department or, in fact, within the Congress?

Secretary SCHWEIKER. This Commission was set up in compliance with Public Law 96–180, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1979. The Commission is mandated by the Congress to conduct a 2-year study of alcoholism and to report its findings, conclusions, and recommendations to Congress and the President.

Initial steps to implement the Commission have been taken including the selection of members and scheduling of preliminary discussions. I might say, all this occurred before I came aboard. There was authorized about $1 million over a 2-year period to support the Commission. Because it was too late to be included in the budget is the reason that I proposed the reprograming.

I guess the answer to your question is, to comply with the law, No. 1. No. 2, because alcoholism still is a growing and rising problem, because I think there is some feeling in the alcoholic community that some of the programs we have been spending money on haven't been hitting the mark, some of them have missed the mark, are not directed in the right ways, and so, of course, the Commission was formed.

As you know, former Senator Harold Hughes, who is a former alcoholic and chaired the Alcoholism Subcommittee in the Senate when he was here, is chairman of it.

I think the idea is to take a look at how and why we're spending funds and whether we ought to be taking a different approach to some of our alcoholic problems in terms of Federal investment, research, and related programs.

Senator SCHMITT. Do you think the Commission can provide you insights that you can't get within the Department?

Secretary SCHWEIKER. I believe the Commission will give us an outside perspective, and I think it will serve to be even more useful now with the proposal to block grant certain components of this program to the States, while still maintaining a national focus on biomedical research for alcoholism.

I think I should probably say, it's even more necessary to advise us as to how we are reorienting our structure and whether we're going to be able to do something for the alcoholism problem under this approach that we have in mind or whether there are some other factors we ought to consider.

ALCOHOL-DRUG ABUSE PROGRAMS

Senator SCHMITT. This subcommittee has asked a number of witnesses, formally and informally, to provide us with quantitative evaluations of the Federal alcohol and drug abuse programs. To my knowledge, nobody seems very comfortable with that. Usually what you get back are examples of specific local projects where it appears it's been successful. In terms of a national evaluation, it just doesn't seem to exist.

Why would we expect this Commission to do any better than others have in the absence of clear-cut evaluation information?

Secretary SCHWEIKER. Of course we made a couple of judgments in our block grants that I think are worthy of repeating here because I think they go to the heart of your question. We felt that some of the expenditures for alcoholism were controversial in terms of their effectiveness, not in terms of their need or merit. By the same token, we felt that the most promising research has come in the biomedical field, so we did not significantly change the biomedical research component of alcoholism. We left that pretty well intact.

On the service delivery aspect where there seems to be a philosophical divergence about how you treat alcoholics, what's the best way to have them returned to the mainstream of society, there is a wide variety of thought. This is why we block granted it, to allow the States to determine on a local basis, with a little more sensitivity perhaps, what the best programs are.

I think we need some objective force, since there are people who strongly believe that AA and its auxiliary organizations are the only real way to proceed outside of the biomedical research area. We know other behavioral scientists who feel that some of the Federal grants and programs have been effective and do perform a role.

I would have to say that there's an honest and wide variation of opinion, and that's the purpose that I hope an Alcohol Commission could perform—to assess, advise, and redirect the focus of our program.

I think everybody agrees that the problem is paramount. We should be spending money in the area. Where we really differ is how to spend the money and why. That's what I hope the Commission will resolve among the alcoholic community.

Senator SCHMITT. You mean the alcoholism community?

Secretary SCHWEIKER. It depends which side of the barrier they're on, Mr. Chairman. [Laughter.]

COMMUNITY MENTAL HEALTH CENTERS

Senator SCHMITT. Mr. Secretary, with respect to the funding of the community mental health centers, what is being done to encourage the State and local governments to assume a greater share of the support for operating such centers?

Secretary SCHWEIKER. In the block grant proposal, we believe that giving the States greater flexibility, without the Federal mandates, will give them a lot more encouragement and incentive to do their own thing.

We believe that the Federal structure of the categorical programs stymies initiative and stymies participation. Now that they have the money through the block grant to spend, without the Federal structure, we believe that, with the community support from the mental health community, there will be encouragement to spend since there has been an ongoing program, because they won't have the Federal constraints and requirements that they had before.

Senator SCHMITT. Is there any way to apply incentives so that the programs that seem to be effective are encouraged and those that are not are either weeded out or encouraged to change their approaches so they are effective?

Secretary SCHWEIKER. We have looked at several, Mr. Chairman, and it is difficult to come up with what I would consider to be a fair yardstick.

Whenever you deal in the areas of social behavior, you have social scientists honestly disagreeing about what is effective, what's working, and what isn't. So, we have not been able to come up with a yardstick that we felt was equitable or national.

That's why we hope that the States, who are closer to some of their own problems, populations and needs, will make that assessment perhaps a little more accurately than we have or can.

Senator SCHMITT. You're saying there is no way to effectively measure a cure of alcoholism.

Secretary SCHWEIKER. You're not talking mental health now? I realize they're tied together.

Senator SCHMITT. I am still thinking of alcoholism, but the general problem is quantifying success in treating mental health, alcoholism, and drug abuse and this kind of thing.

Secretary SCHWEIKER. It is very difficult. I just went through the process of interviewing maybe a dozen candidates for the ADAMHA Directorate, the head of the whole group. I asked each one that same question. I didn't get two answers that were anywhere near the same. There's absolutely no unanimity of thought, concept, or even basic agreement on how to best proceed.

Maybe that's good and maybe it's bad, but for one who has to look at where the money is being spent and also determining if it is being done right, it's a little disturbing. And, I guess that's one of the reasons that I feel the Commission might give us a little further grip on it. But there was certainly no accepted consensus that I could work with.

You have those who strongly believe in the biomedical research component as the key, others who believe in the AA approach, and still others who believe in the local community mental center approach.

I don't have the statistics on any of them to really back up anybody's support. And that's half the trouble.

Senator SCHMITT. Do you think there's enough?

Secretary SCHWEIKER. The only statistics we have are those which say it's a tremendous problem, it's probably getting worse, and we're not sure what to do about it.

Senator SCHMITT. Do you think that we need more field research and less laboratory research?

Secretary SCHWEIKER. I think we certainly need more biomedical research. If there's one breakthrough—and I shouldn't use the word "breakthrough"—if there's one growing indication, it is that the chemical addiction of alcoholism and the biomedical reaction of alcohol to the body is probably the one new upbeat thing that we've seen.

I am encouraged, with my interest in health research, that if we pursue this further, we well may find some kind of a substance that would help break up that dependency. I personally believe that in the long run that's probably where we might find an answer.

But I want to say that I'm not an expert either. A lot of people wouldn't agree with that, but that's the way I would go initially.

On the other hand, I think the AA has shown as well as anybody, that if you are going the other way, then they have some answers.

Senator SCHMITT. Mr. Secretary, we've been together off and on here now for several days, and I don't remember whether I've asked you this question or whether it was some other witness.

Secretary SCHWEIKER. Since I've been through 12 hearings on the Hill, I probably won't remember either, Mr. Chairman. [Laughter.]

Senator SCHMITT. Only 12? [Laughter.]

HEALTH EFFECTS OF BAD HABITS

It has been suggested that since the major causes of loss of years of life is related directly or indirectly to bad habits that maybe we should, for those bad habits that can be quantitatively identified, through designated taxation, pay for the cost of that future health care.

Do you see any way in which that could be done? Tobacco and alcohol being the two obvious quantifiable commodities.

Secretary SCHWEIKER. Well, of course, I certainly feel there is a relationship between the two in terms of the debts and the costs that society has to pay. I don't think there's any question about that.

When we've had discussions of that at the budget and fiscal level, I haven't been able to have that point of view prevail in terms of my budget and some of the other aspects of it.

So I would have to say that when you get into an accounting argument, there are not many people who see that. I happen to think that there is a very specific relationship, in terms of society's costs. But whether we'll be able to translate that into something specific is pretty difficult, in light of my earlier discussion.

Senator SCHMITT. You don't find any disagreement with the fact that those who do not participate in such bad habits—they may have others of their own, but who do not participate in those—are now obligated to bear the costs through tax dollars and through their own increased medical costs of somebody else's bad habits?

Secretary SCHWEIKER. Mr. Chairman, I can't disagree with that logic.

Senator SCHMITT. Do you find any disagreement within the administration?

Secretary SCHWEIKER. When I started talking that way at a few meetings I have attended, I found that I was talking to accountants who didn't perceive that perspective and didn't really——

Senator SCHMITT. Accountants or politicians?

Secretary SCHWEIKER. In this case, they were accountants who were trying to balance by looking at where revenues were coming from and going to. That was their main concern, so I didn't make any gains with my argument.

Senator SCHMITT. But they weren't interested in increased revenues from this source in order to help balance the budget, at least the portion of it dedicated to future health care costs?

Secretary SCHWEIKER. I made a case for decreased tobacco subsidies, and it didn't get anywhere. That will give you the picture, I think.

HEALTH PLANNING PROGRAM

Senator SCHMITT. Mr. Secretary, we note that you proposed to phase out the federally funded health planning program, presumably cutting off 213 local health systems agencies, HSA's, and 57 State planning organizations.

Since health planning is a relatively new effort, as supported by the Federal Government, why not try to make it work rather than shut it down?

Secretary SCHWEIKER. First of all, we are trying to stretch out the timeframe. Initially the proposal was to shut it down at once. I think I was successful in getting a several-year grace period. We are going to look to see if there is any way to keep some elements of it alive.

While you were out, I did go into it with one of the other Senators who was asking a similar question. I think that we have not ruled out using certain elements of it in a new health proposal, but it is awfully difficult to do. I am open to ideas on it.

There have been a number of studies—not a number, but some, that contradict whether they are beneficial or not. In fact, we had one done by the last administration under Secretary Harris, an evaluation of the effects of certificate of need programs, by Policy Analysis, Inc., in Brookline, Mass. Again, it was done for the last administration, so it did not contain any kind of a pro- or anti-perspective, since the last administration supported these programs.

Basically, it says that the certificate of need programs have not constrained either hospital investment or hospital costs. It also stated that in the States where they are operative, in many cases some of the providers have actually found a mechanism to get around it, either through a loophole in the planning process or by exerting pressure on the local HSA to get their perspective point of view.

The evidence, again, is perhaps contradictory. But our Department's study doesn't give us too much encouragement about the savings.

Senator SCHMITT. I don't know whether the PSRO evaluation has been done by the same people that are evaluating the health systems agency, but it sounds like you've defined the same problem. There's conflicting information, depending on where you look.

The real question is: Is there a way to quantify the benefit costs of such an activity? If there is, then you may be able to apply the same kind of proposal.

Secretary SCHWEIKER. The CBO did the PSRO one, Mr. Chairman. The other one was a private contracting study. They well may have come up with similar general points of view, but they were actually two independent studies, one in the private sector and one in the public sector.

Senator SCHMITT. We'll try to provide you with some suggestions on how one might quantify health planning benefits.

Secretary SCHWEIKER. I'm intrigued with that, because I can see some benefits to those programs. I know there are some areas that are quite effective and other ones, where they have turned into political warfare and have been disasters.

Senator SCHMITT. There is a problem, and you'll have to deal with that. That is, there tends to be some conflict between the State planning agency and the HSA. HSA tends to be more focused on the local community, and they have the local community involved in their activities. Whereas the State planning agency tends to be more of a bureaucratic approach at a central point.

At the same time, I think there are examples where unneeded facilities have not been built. Now, I'm sure there are some who would argue that needed ones have not been built, also. But we're not as aware of that.

Is that all you have on that, Mr. Secretary?

Secretary SCHWEIKER. For example, just a few highlights of this particular report: Overall, we found no evidence sufficiently strong to demonstrate that any of the characteristics of the certificate of need programs that we included in our equations were associated with reductions in the rate of accumulation of local hospital capital stocks; the evidence in toto leads us to conclude that the certificate of need programs have not significantly reduced the rate of growth in capital stocks in the hospital sector; we concluded that certificate of need regulation has not significantly inhibited the annual rate of growth in hospital costs; and, the results of our regression analysis did not provide any strong statistical support for the hypothesis that mature certificate of need programs have been effective as cost control mechanisms.

I can go on. And again, this was done by the former administration, and was an outside, supposedly neutral, evaluation.

Senator SCHMITT. Could we get a copy of that for our records?

Secretary SCHWEIKER. Yes.

[CLERK'S NOTE.—The information is being retained in the subcommittee files.]

BUREAU OF HEALTH PROFESSIONS REDUCTIONS

Senator SCHMITT. Obviously, as you say, there's conflicting information. And we would like to study that.

With respect to the Bureau of Health Professions and reduction in force, your budget indicates you propose to reduce the staff in the Bureau of Health Professions from 413 positions in the current fiscal year to 100 positions in 1982.

Would you summarize the purpose of such a major reduction in force?

Secretary SCHWEIKER. Mr. Chairman—we have not yet—unfortunately, from your perspective—sent up the health professions bill, but it would relate to that legislative proposal, one feature of which is to reduce significantly the capitation grants to the schools involved. So it is premised on a reduction of the Federal role in the sector on health professions.

Now, we have targeted some areas that will not be reduced, such as primary care, some special nursing projects, nurse practitioners, and some others. But there is a significant reduction, and that reflects it.

Senator SCHMITT. OK.

We look forward to your more detailed proposals.

Mr. Secretary, have you worked out yet a way to mitigate the impact of needed slots for the newly graduated members of the Public Health Service? You and I discussed that over the telephone.

Secretary SCHWEIKER. Yes; we have a list here, if I can just get it.

Senator SCHMITT. The problem being—while we're waiting—so the record is clear, that the obligation to newly graduated health professionals exceeds the number of slots available to place them, as I understand it.

Secretary SCHWEIKER. We're going to propose a list of about eight options that I would have, as Secretary, to pursue. One of them would be to provide for an extra incentive for the people in the program, to take the private sector participation in an underserved area, which is where we hope they'd all go anyway, in terms of the private sector or rural delivery system.

Another would be to change the definition, so that we have a chance to utilize them in some differing areas, excepting those who voluntarily opt for the PPO in the high-priority HMSA areas 1 and 2, and permit the PPO'ers to go to low-priority HMSA's 3 and 4, to ask them to serve the Department of Defense shortage need for VA and also to allow them to serve where hospitals are really critically short.

In addition, give the option to revise the BIOC division. These are about all the proposals we would make.

We ask for the authority to utilize these in differing ways than we currently do. My own preference is to utilize them in the areas that we were intending, so the PPO route, to me, is the most promising. But we would utilize their services, not waste them.

Senator SCHMITT. The object being to reduce the number of individuals currently in place that would have to give up their slots that they currently hold.

Secretary SCHWEIKER. We will be graduating with our 2,500 goal, we will for about a year, have 300 extra. The year after that, maybe 600 extras is all we're talking about. After that, the problem will be solved. So during the next 2 years, as I recall, we are talking about 300 one year, and possibly 600 another year. So we would try to work out a proposal that would utilize them in one of these capacities.

I like the PPO option, because that is where we want to put them. So, we are going to try to do that.

Senator SCHMITT. How soon would those people potentially affected, who are currently in the field, have some certainty in what their future was going to be?

Secretary SCHWEIKER. Well, in the fiscal year, there would be about 136 people involved. Are you talking about the field strength or the people in the total program?

PHSC ASSIGNMENTS

Senator SCHMITT. I guess I'm talking primarily about the field strength. The basic issue is that there are people out in the rural areas who are currently providing service in the Public Health Service Corps who have been informed that they will have to give up that slot, in order to give the option to a new graduate. There is uncertainty as to whether the new graduate will select the slot that's been given up.

It's really a twofold burden. It's a burden on the provider, but more importantly, the community doesn't know if they're going to have anybody to replace that provider.

Secretary SCHWEIKER. There are about 300 people in that category that we're talking about. We would propose asking for the authority to do one of these things. My highest personal priority would be to locate them in the areas where they're most needed.

Senator SCHMITT. Where there is at the present time no provider?

Secretary SCHWEIKER. Exactly. That would have the highest priority.

Senator SCHMITT. Mr. Secretary, does that take legislative action to implement that?

Secretary SCHWEIKER. Yes; the only problem is, we have drafted the bill. I believe it's either at OMB or on the way.

Senator SCHMITT. Presumably in the next few days or a week or so, we would have that. We can indicate to the individuals who are concerned and corresponding with us, what their options may be, should the Congress act.

Secretary SCHWEIKER. OK.

PHS HOSPITALS

Senator SCHMITT. Mr. Secretary, in the Office of the Assistant Secretary for Health, you are requesting $127.7 million supplemental for fiscal year 1981 to cover termination and closeout costs related to the program and staffing changes you intend to make elsewhere. What is the authority for this supplemental request? Are you asking us to authorize and appropriate at the same time?

Secretary SCHWEIKER. The authority is one of general statutory authority in the Public Health Service. It's primarily for the closure of the Public Health Service hospitals in terms of settlements for termination pay, in terms of costs of closing, and in terms of reduction in force. That's under general authority.

Senator SCHMITT. Is it your counsel's opinion that the authorization for such a supplement is inherent in the authority you currently have?

Secretary SCHWEIKER. Say that again.

Senator SCHMITT. The authority for such a supplemental is inherent in existing law. Is that your counsel's opinion?

Secretary SCHWEIKER. There are two things you have to deal with here. I think that's right, but the first part of it is, the authority that we are asking for there is correct in the law, basically. On the other hand, the objective is closing the hospitals. We have sent up a bill that has to pass in order to effectuate that other goal.

Senator SCHMITT. That will include authorizing language.

Secretary SCHWEIKER. No; the point is, you can't do one without the other. In other words, we have the authority now to spend the money for RIF's. We have the authority to spend the money for termination, et cetera. We do not have the authority to close the hospitals. So it's a two-tier thing. If our legal counsel is right in saying we have the authority to do one, obviously, we cannot proceed in doing the other.

Senator SCHMITT. So you're saying that the $120 million supplemental is based on the assumption that you will get the legislative authority to close the hospitals?

Secretary SCHWEIKER. That's correct.

Senator SCHMITT. If you get that legislative authority, you need no further authorization in order for us to give you $120 million?

Secretary SCHWEIKER. That's also correct.

Senator SCHMITT. Could we have your counsel's summary of that legal position and citations?

Secretary SCHWEIKER. Yes.

Senator SCHMITT. For the record.

Secretary SCHWEIKER. We have suggested some language to the committee here that might help some of this. I'll just read it into the record:

> For an additional amount for salaries and expenses, $120,729,000, to remain available until September 30, 1983. Such sums may be transferred to other appropriations of the Public Health Service to pay costs associated with the reduction or termination of the various programs of the Service.

So that would be authorization.

HMO PROGRAM

Senator SCHMITT. We would like to have a legal brief on that language and on the other aspects of it. Mr. Secretary, with respect to HMO's, will a complete cutoff of Federal dollars for new starts, as well as expansions, have a dampening effect on private sponsorship?

Secretary SCHWEIKER. Two out of every three HMO's today are being financed without public money, and we really believe that initially when we started the program, the idea of Federal money was to be for demonstration and startup to prove the feasibility of it, until the idea was thought out by the private sector. We really believe now that two out of every three HMO's are being formed with private money. Groups such as INA, CNA, Prudential, Reynolds, Phillip Morris, a number of Blue Cross groups across the country are now putting the money in.

So we just don't feel that the Federal subsidy part of the money is needed. I want to make clear we strongly believe the HMO's are needed, and we're going to do several things in the new HMO bill to do that. We're going to change the requirements under the law. We're going to have the HMO mandated to provide somewhat less services, make them more competitive with the fee for service groups. We're going to let them select whether they want an experience rating or community rating. That would require one but not the other.

We are going to let the independent practitioner group, the IPA group, a kind of HMO, be structured without the corporate procedure that we have required under existing law. We're also going to wipe out the requirement in our medicaid program that prohibits HMO's from participating, unless they have a certain mix between medicare and medicaid patients. That stops HMO's from being utilized there.

So all these things we're going to recommend legislatively, and then in addition, we are also going to keep the Federal certification process, so that people will know, and also keep the requirement that an HMO, if it is available, must be an option to employers.

So we're keeping those two.

Senator SCHMITT. OK, sir; we'll have some additional questions for the record on HMO's.

OFFICE OF SMOKING AND HEALTH

You have requested a $993,000 rescission for the Office of Smoking and Health. What will be the impact of this decision on personnel, programs, et cetera?

Secretary SCHWEIKER. Mr. Chairman, this was an area where initially OMB had proposed to stop the program. I opposed that, and we restored about half the money. That is what this relates to.

Senator SCHMITT. Do you expect to have to dismiss personnel?

Secretary SCHWEIKER. Do we expect what?

Senator SCHMITT. Do you expect a reduction in personnel in that Office, as a result?

Secretary SCHWEIKER. I'm going to try to do what I can to keep our nucleus together. Most of this is program money, so hopefully there will not be too much reduction of personnel. I believe it is an important program. That is why I appealed it, and I believe it is important to carry on. I might say, this has not gotten too much publicity, there are about $30 million of research money at NIH being directed toward the problem of smoking and health, so everybody focuses on the $3 or $4 million in terms of this program. I happen to think it is a good program, but we lose sight of the fact that there is around $30 million in the NIH Institute on Smoking and Health, and I believe that has not been curtailed nor cut back in any way. I think it would be foolish not to take advantage of what we do in research and promulgate it through our agencies. So I'm going to try to do that even with the limitation of funds.

MEDICAID CAP

Senator SCHMITT. Mr. Secretary, the administration has proposed a cap on medicaid expenditures, which will reduce outlays by $1 billion in 1982. As you are aware, the National Governors Association and a significant number of other organizations opposed a cap. Most recently, the Senate Budget Committee also rejected a cap and instructed savings in medicaid and medicare totaling roughly $1 billion. The fact that the Senate Budget Committee rejected the cap is legally meaningless, but it does indicate an attitude within a certain part of the Senate.

In light of this opposition, does the administration plan to change its approach in any way?

Secretary SCHWEIKER. We have always viewed the cap as an interim measure. We believe there are some constraints in medicare now, such as number of hospital days that a patient can stay. There are some limits on the days in a nursing home. Under medicare, people have to pay a copayment plan. We also have some fiscal constraints now on medicare. Medicaid has been an open ended blank check, and we feel has been one of the contributing forces to driving up State costs, driving up inflation and the expansion of social programs. So we are using this as a temporary vehicle to slow the rate of growth. I think it's important to note that with our changes in the laws that we're asking the States to make, with our mandated programs, they will save $1 billion. So if there are any losses, they are going to have another $1 billion of revenue which they can utilize, if there really are any such losses.

As to the actual reduction, we are allowing the cap to go up 5 percent the first year. After that, it will go up by the gross GNP deflator. But the first year it is going to go up 5 percent, and if you look at the total impact of that $1 billion cut, it is a 3-percent cut in total spending on medicaid. Our belief is that when you give the State the right to buy in bulk, for example, drug supplies, or when you give them the right to procure contracts on a competitive bid basis, to use HMO's and prepaid group plans, they will be able to save 3 percent.

We believe they can do it. Obviously, the States have some doubts about it, but they have another $1 billion that people keep forgetting about, that the law also allows them, of returning money to the States, under mandates of the welfare program.

Senator SCHMITT. Thank you, Mr. Secretary. It's my intention to finish by 5 o'clock. We have a few more important questions, and we'll submit the rest of the questions for the record.

[A brief recess was taken.]

MEDICAID AND MEDICARE COSTS

Senator SCHMITT. Mr. Secretary. It's been alleged that medicaid and medicare actually are the cause of increased health costs. Do you think there is any substance to that?

Secretary SCHWEIKER. Yes; I think there's some substance to that, Mr. Chairman, because the Federal Government is now paying 40 percent of the hospital bills in this country because of medicare and medicaid. So we have rung up the demand way beyond what it was. I think that to some extent we are partially involved in running up demand; yes.

Senator SCHMITT. Do you think there is also, because of its existence, a tendency to charge and to do things that otherwise cannot be done within the providing community.

Secretary SCHWEIKER. I think as long as we have the Federal Government picking up a big chunk of the tab and doing it on a cost-plus basis, you'll have the same effect here as you have in the private sector. In wartime, when you awarded cost-plus contracts, you had a tremendous amount of waste, inefficiency, and even fraud. So I don't think it is necessarily attributed to the public sector. I think it is a mechanism of cost plus. That is one of the reasons we hope to come up with a plan that will get away from that.

But I think that's certainly one of the components of it.

Senator SCHMITT. Are you examining cost-plus incentive fees?

Secretary SCHWEIKER. We're examining, instead of cost plus, some kind of contractual bidding basis or prospective reimbursment basis, where you're bidding to provide a service and have to keep within a certain budget constraint or have to agree to a certain competitive bid and do it like the private sector in other areas does it. The prepaid group health insurance program is an illustration of this, where you're paying a set fee to keep a person well. We are exploring a number of things like that.

COST-PLUS CONTRACTS

Senator SCHMITT. Have you examined the concepts of a cost-plus incentive fee in those contractual arrangements? Or have you set certain goals that if they're met, they will be fee related?

Secretary SCHWEIKER. The answer is, we will be looking into an incentive fee; yes. In fact, I had a decision on the medicaid cap proposal with the other body. One of the areas that we'll be looking into as a result of our discussion there, is to have some equity to the States on those who have performed well, and those who have done well in the past, whether it can be some recognition of that in the cap and, therefore, some incentive to the State that has done well. So we will be exploring that. I don't want to promise that we'll come up immediately with something specific here, but I think equity demands that we do explore the cap area.

But I also think if we want the program to work, we need incentives. So, the answer is yes.

Senator SCHMITT. There are other agencies of Government that have been working in the last decade or so with cost-plus incentive fees. I think in some agencies like NASA, it's proved successful. I don't know whether the experience is directly translatable, but if you have it, it might be useful for your procurement people to get with theirs and see if there is any experience transfer that would help in this situation.

Mr. Secretary, I think most of the questions on PSRO were handled on an ad hoc basis.

SSA INCREASES

Now with respect to the Social Security Administration, the Reagan administration has requested an additional $67.6 million for the continuance of the reserve in the limitation on adminstrative expenses, in order to make sure that all of the work required to implement the President's social security initiative can be accomplished quickly after enactment of the administration's proposal. Why is the $67.6 million necessary?

Secretary SCHWEIKER. Well, Mr. Chairman, for a couple of basic reasons. If the Reagan administration proposals go through to abolish the minimum monthly benefit of $122, we will have to go back in the cases of 3 million recipients and figure by hand what their actual benefit should be. The computer does not have on it the benefit beyond the $122 figure. Rightly or wrongly, sometime back, when the computer data input was decided upon, somebody decided not to put what the payment would have been, if there wasn't a minimum fee. Maybe they didn't know what would happen in the future, obviously, so there are no computer programs available. We have to physically go back, mechanically, by hand and figure each person's case and entitlement.

This is also true to a lesser extent of the other benefit involved, in terms of disability and the student benefits too. While the calculation there isn't as overwhelming, we just figure it will take *x* number of people to do it. We have made an estimate of what that is, and that is what that money is for, I believe it will require 3,465 man-years to do that.

Senator SCHMITT. When do you expect to have the job complete?

Secretary SCHWEIKER. It's going to be difficult to meet that deadline that has been imposed upon us because of the timeframe that the Congress has to act within. It would not make much sense to start putting money and expending the effort, if it was to no avail.

By the same token the Congress probably will not make this decision until further down the road, a few months from now, and so when you're talking about when the Congress makes its decision and then October 1, we're going to be in a real tight timeframe. We will need the additional people, there is no question about that. However, whether we can meet that timeframe is debatable.

Senator SCHMITT. How many people are we talking about?

Secretary SCHWEIKER. We said 3,450 man-years, which is basically 3,450 people for a year.

Senator SCHMITT. Are you exploring the possibility of completing it in a shorter period of time with more people?

Secretary SCHWEIKER. I'm sorry, I gave you figures for just 1981, and there's another 8,826 man-years—I should say work-years—that we're going to be needing in 1982. So that's what we're talking about.

They probably would be nonpermanent employees, and some would be overtime, so I don't want to say that we're going to be hiring that many people permanently. That is not the right assumption.

Senator SCHMITT. Will you do any contracting?

Secretary SCHWEIKER. All in-house.

Senator SCHMITT. That sounds like quite an undertaking.

Secretary SCHWEIKER. It is. It's a shame, though, that it wasn't computerized.

Senator SCHMITT. There's no software fix? No way to get it on the computer?

Secretary SCHWEIKER. The basic data on the computer contains a minimum benefit and not enough other information to make any calculation from what they would be entitled to. I can see the people that initially decided that probably never envisioned that this would occur. So I really can't fault them too much, but that's the problem.

SSA COMPUTER PROBLEMS

You know, one thing that we really ought to call attention to, and I forget if I mentioned it to this committee, we are really in a serious problem with computers for the Social Security Administration. We have computers that are one or two generations old, they're not current, no up-to-date business corporation that does the amount of volume of business that we do would have them. We've never invested enough new capital to get the latest equipment. We are in the process of moving their computer headquarters for the very simple reason that they have been in a building that cannot handle the special requirements of modern computers. I think the committee should be aware of this, because we are going to have to come back to the committee at a later date, to request additional resources. We are in a situation where we have a national computer center for all of our social security options across the country. When somebody goes in to ask for a claim or wants to get a response, they are tied into the computer net in Baltimore.

Every once in a while, about once a week or so, the power goes out in Baltimore and the computer goes down. As a result, the whole country comes to a stop in the social security offices because we can't keep our computers going. We have no auxiliary power supply for our big computer network, so, when everything just blanks out, people all across the country have to wait, leave, or come back if there's a power failure in Baltimore.

For that reason we have a new building that we are moving into which has an auxiliary power supply for emergencies just like that, and also, a lot more security than we have now. We are in the process of moving into this building because we have computer tapes and not even the disks that most businesses are operating on. We have to lug and transport the tapes from one building to another. It would be a miracle to get it online using the older system we now have as well as the tapes without making mistakes. We have a horrendous computer problem just moving from one building to another.

Senator SCHMITT. You're moving the old computers?

Secretary SCHWEIKER. They are relatively old. In other words, they're two generations old. That's the problem.

Senator SCHMITT. When were they installed?

Secretary SCHWEIKER. There are 47 large- and medium-sized computers in the Department. SSA has 30 of them. None of the SSA computers are still manufactured presently. They are not on the production line anywhere. They are very inefficient from the standpoint of the number of people needed to operate them, the physical space they take up, and the electrical power they consume. It restricts our ability to expand to meet current requirements because of the limited capacity of the older equipment, and thereby forcing the SSA to rely on manual labor or expensive outside contracts.

It also forces SSA to unnecessarily seek costly automatic data processing operations because of the excess in effort required to patch and maintain very old hardware. Let me say that upgrading the system is a very high priority with me and I will be coming back to the Congress with some recommendations.

We have budgeted a very small amount, about $7 million, to begin systems enhancement this year and about $58 million for 1982. That is just the beginning, you know. We're one of the biggest checkwriting operations in the world, and we have some of the worst equipment.

Senator SCHMITT. Have you discussed this within the administration yet, or are you still formulating it?

Secretary SCHWEIKER. Yes; part of the trouble is that we are tied into a very early system and because we tied in early, when they first had the technology knowhow, we have been criticized by some congressional committees for using a sole source supplier. Back then that was the best source we had. So as we bought into the system we stayed with that supplier. But now we are being pressured to make it a competitive bid situation.

If we have to spend money for a competitive bid situation, we are actually spending money to update old machinery to satisfy a competitive bid requirement, when, in fact, we ought to be buying new equipment. But there are some strong feelings in Congress and in the House regarding competitive bids. It has forced the SSA to worry about competitive bids for old equipment instead of acquiring new equipment from scratch.

We have been caught in a little bit of a crossfire. I'm going to try to find a way out of it and recommend some money for the Congress to invest in new computers, but it gets back to the problem that we need manual labor to make changes.

Senator SCHMITT. We will not look forward to that request, but we'll certainly treat it.

Secretary SCHWEIKER. In fact, if the chairman has some time, I'd be glad to set up some visitation with our computer system in Baltimore, because I really think it is just astounding—it was to me—as to what kind of equipment we are running this whole social security system on. It is almost miraculous that they have done as well as they have with this old generation equipment.

Senator SCHMITT. I've been involved with old generation computers as long ago as 10 years ago, and I know what happens to them. You spend most of your time trying to get them back up again. Particularly, I know the generation you're talking about. It's particularly susceptible to problems after power failures.

SSI BENEFITS

The fiscal year 1982 Reagan budget estimate for SSI benefits is $115 million lower than the Carter administration request in fiscal year 1981, yet the Reagan administration admitted that SSI costs would increase as the social security minimum benefit is eliminated.

Does this budget request for SSI reflect the proposal to eliminate social security minimum benefits, or do I not understand the situation?

Secretary SCHWEIKER. Let me ask one of my staff to give it to you here, since it is a rather complicated answer. If you could just identify yourself.

Mr. STURMAN. I am Michael Sturman. There is no reduction in benefit payments in the Reagan budget. In fact, there are increases under proposed legislation of about $300 million as an offset for the change in the minimum benefit. The reductions within the Reagan budget are primarily in three areas.

One is the recommendation to eliminate the SSI hold harmless payment, that is $45 million; there is a recommendation to eliminate the vocational rehabilitation program for the SSI, that accounts for $20 million; and there are changes in how Federal fiscal liability will be calculated. This is a quality assurance activity related to our administration of supplementation payments. We are recommending in the case of the SSI program that it be tied in within the AFDC penalty system—that is, where we provide the States with error sanction waivers in the

AFDC program, we would not provide a Federal fiscal liability payment to those same States. That accounts for most of the reductions.

Senator SCHMITT. Let's make sure we work this one out. It's pointed out here to me, that the $115 million decrease is in the Federal benefit payments. Do you agree with that, and what you've described are in other items.

Mr. STURMAN. Between the Carter budget and the Reagan budget there is a decrease. However, that is not a new policy change, it is a change due principally to the revised economic assumptions as well as improved bank account verification procedures. The Reagan budget had a higher estimate of the cost-of-living increase that affects both social security and SSI, and the projection now for 1981–82 is lower in the Reagan budget. That accounts for the benefit payment change.

Senator SCHMITT. Lower than the Carter budget?

Mr. STURMAN. Lower than the Carter budget.

Senator SCHMITT. Is there any impact in the reduction on minimum benefit on SSI costs?

Mr. STURMAN. Yes, sir; there is. In the proposed legislation once the minimum benefit changes under social security title II are enacted, SSI costs will increase by approximately $300 million. That increase would be transmitted to the committee after enactment of the legislation.

Senator SCHMITT. That will be a separate item?

Mr. STURMAN. Yes, sir.

AFDC PROGRAM

Senator SCHMITT. Thank you. I think we've got that.

Mr. Secretary, in aid to families with dependent children, the administration is recommending a series of major reforms. Among these is a proposal to require States to establish a workfare program. How would you envision this program operating?

Secretary SCHWEIKER. Mr. Chairman, we are not going to prescribe workfare rules. We basically are going to ask States to have a workfare program, and we are going to leave it up to them as to what kind of program they want. We feel that this is primarily a State approach, so we will not have any Federal standards.

I think it should be said that our ultimate objective is to come up with a proposal that would block grant the AFDC program to the States. We do not have it presently, we may later this year. At that point they would have a complete say as to whether they wanted a workfare program or not.

But in the interim, until we have a block-grant program, we are asking—requesting that they have a workfare program. The workfare program would be pretty well left up to their discretion.

Senator SCHMITT. Then you would not have any requirements on the States on who participates or how the program is structured?

Secretary SCHWEIKER. That's right. They would have to submit a plan. It would be my intention that as long as it looked reasonable, we would not have a model Federal workfare program, model guidelines, or special standards.

Senator SCHMITT. What would be the criteria for reasonableness?

Secretary SCHWEIKER. Some good faith effort to show that they were proceeding in a sound—well, I would not say sound, but proceeding in a sincere, conscientious effort to have their own program.

We feel each State should dictate the nature of the program, how much people can participate in it, what kind of jobs would be available, and under what conditions would they have to do it.

Senator SCHMITT. What if they chose not to have workfare?

Secretary SCHWEIKER. We are asking for legislation that would make it mandatory.

Senator SCHMITT. I don't see how you're going to make it mandatory and not have some minimum requirement.

Secretary SCHWEIKER. They would have to submit a State plan, but what I am saying is that we would be very flexible as long as we felt there was a reasonable approach and some kind of work of a constructive nature was involved. We would leave that to the States to decide, but they would have to submit a State plan and we would have to make a judgment that it was a good faith effort to have a workfare program.

AFDC DIFFERENCES BETWEEN STATES

Senator SCHMITT. What if there were significant differences between the plans for Pennsylvania, New York, and New Jersey. What would be the consequences?

Secretary SCHWEIKER. We would have no objections to that. We feel that would be all right.

Senator SCHMITT. Do you think there would be some incentive for those, say three States, to pick an example, to try to come up with a program that was roughly comparable so there would not be any inequities across those State lines?

Secretary SCHWEIKER. Again, I think this would be no more true than some of the other State directed programs, but obviously my guess is that the States that live near each other might well try to have similar programs, but we are not going to require that.

Senator SCHMITT. What about training programs as a supplement or complement to workfare programs. Do you view those as important aspects of the plan?

Secretary SCHWEIKER. First of all, let me say that there probably would be training money in certain block components to the States, so we would expect that there would be training components. We would have to look and see that they were utilizing or supporting a program for some training, but I think the answer is, "Yes."

Senator SCHMITT. Have you and Secretary Donovan discussed this? They do provide some vocational training efforts with respect to AFDC.

Secretary SCHWEIKER. We've had some discussions of it, yes, but we haven't arrived at any joint approach because I feel that basically it should be, and the administration feels, that it is primarily a State prerogative. But we certainly would want to see a training element so that people could be assisted in obtaining a job in the private sector, so that would be a key aspect of it.

Senator SCHMITT. We'll be very interested in the proposal, probably more interested in how it works out since you're not going to have any great detail in the requirements.

ENERGY ASSISTANCE

The administration proposes to create a block grant, which would combine the functions of a low-income energy program and the emergency assistance program previously funded under assistance payments. The administration further proposes to reduce funding for these purposes 25 percent below the fiscal 1981 level.

How would you expect the States to administer this program?

Secretary SCHWEIKER. We gave the States some flexibility the last time we wrote the bill. I guess it was last year. Obviously, there would have been even more flexibility than now, but I would expect that since we just went through this procedure and since the States have come up with their own basic plans, that they probably wouldn't change them too much. In other words, my guess is they would just pick up from where they left off by making any State changes that they felt were relevant. Again, this would be a block grant thing, so they could do what they wanted with the plan.

Senator SCHMITT. Would there be any services provided by your Department?

Secretary SCHWEIKER. We have a transition task force and we would make available whatever services the State felt they would need to assist them, but I really believe that since we have just gone through it this past year, the States, by and large, have done a pretty incredible job or there would not be that much involved.

This is probably the one program where we are really not changing that much from what we are doing now, because we have a two-categorical block program. So I wouldn't expect it would be much of a problem.

Senator SCHMITT. The allocation of funds would be on the basis of a combination of the existing formula?

Secretary SCHWEIKER. The same formula that now would be utilized, geared to the new census figures.

Senator SCHMITT. How will you monitor the use of the funds?

Secretary SCHWEIKER. Well, in this one, they would have to file a report on how they were spending money within this block. Now in this particular case, that would be unusual because there are only two elements in the block, and the second element is a very small emergency assistance program. So they would probably put in effect the program they had last year and publish it. After that, they would have to obtain an audit, give it to us and the General Accounting Office. We would then have the right to either send in an Inspector General or to evaluate the program ourselves after we received the audit. So we would have an oversight function.

ADMINISTRATION OF BLOCK GRANTS

Senator SCHMITT. Mr. Secretary, would you expect the States to increase their administrative staffs to handle the block-grant program?

Secretary SCHWEIKER. In this case, I would not, because basically they are administering this program now, unlike some of the other blocks where they might have to build on something. They are really administering it their own way now.

We are relaxing some of our requirements, for example, some States are now required to make payments to operators of subsidized public housing on behalf of their subsidized tenants. Often the amounts are difficult to compute and the guidelines to determine payments are not always clear. In addition, States must submit frequent reports on details of the program, secure complex and lengthy agreements with fuel vendors, and develop detailed and overly specific justifications for benefit levels for payments to eligible households.

Those requirements would no longer be pursued. They could either continue what they are doing in this respect or set up their own standards, so their administrative workload would be decreased somewhat, from the present system.

Senator SCHMITT. You would leave the responsibility to the States to insure that funding was available to those who truly need the benefits.

Secretary SCHWEIKER. That's right.

Senator SCHMITT. In your Office of Human Development Services, the child welfare adoption assistance/foster care program, you're proposing another block-grant program. A number of legislators, including Congressman John Rousselot of the House Ways and Means Committee, favor keeping the recently reauthorized child welfare adoption system/foster care program out of the block grant.

Would you give this committee the basic justification for this particular block grant?

Secretary SCHWEIKER. In the social services block, we have a number of programs that somehow interact with each other. We have adoption assistance, foster care, child welfare services and we believe that by putting these programs together, they can be more efficient and save money. That was the whole premise of the block and the States will be able to combine several different categorical programs that are currently required to be run by the Federal Government. That was the theory and principle behind it.

Senator SCHMITT. Do you believe that in the time since these programs were established that the States have developed the expertise necessary to undertake greater responsibility. Part of the original problem was that they were not doing a very good job, as I recall.

Secretary SCHWEIKER. There's no question that the Federal role has put a heavy mandate on the States in these areas. It boils down to two aspects, one of them is that some of the things the States can continue to do under the block grant system, the other concerns Federal law and Federal mandates. Here I think if there is a Federal component involved, obviously Congress can take a look at that and see whether or not that's something that should be left as it is or not.

But we are reasonable people, and if there is some Federal component, just like there is in the runaway youth program where there is a computer hotline, and there is a Federal component that we want to utilize, we will certainly take a look at it. But we did not intend to block grant it.

HEAD START PROGRAM

Senator SCHMITT. Mr. Secretary, you're requesting a $130 million increase for the Head Start program, despite the lack of renewed authorizing legislation. When will your Head Start legislation be submitted to the Congress?

Secretary SCHWEIKER. I have already signed off on it. It is now currently awaiting further approval from OMB. I think the chances are fairly good that we will submit it fairly soon after your recess. But we do intend to continue it as a national categorical program.

Senator SCHMITT. Have you discussed with the Head Start grantees the possibility that they may have to operate under a continuing resolution at last year's funding level if the authorizing legislation is not acted upon by the Congress?

Secretary SCHWEIKER. You mean after the continuing resolution expires in June?

Senator SCHMITT. In the event that Congress doesn't act on the new authorizing legislation.

Secretary SCHWEIKER. You are not talking to the continuing resolution now.

Senator SCHMITT. A 1982 continuing resolution in order to make funds available to the program until the new authorizing legislation is acted upon by Congress.

Secretary SCHWEIKER. We expect to have the bill up right after recess, so we would certainly hope that it would be acted upon by October 1. I do not see any reason why it could not be.

Senator SCHMITT. You know sometimes these things don't happen.

Secretary SCHWEIKER. Right. But here is a case, Mr. Chairman, where the administration is supportive of the program. We are not block granting it, we are not hatcheting it and I suspect the Congress will support us on it. So unlike a lot of other areas, this is probably one that we might get all the way through in minimal time and we do hope to have a bill out very shortly. So I think we have a good chance.

Senator SCHMITT. You don't think it will be held hostage to more controversial legislation like CSA?

Secretary SCHWEIKER. I guess a lot of things could be held up. I hope Head Start will not be held up when it gets here.

Senator SCHMITT. As soon as you see any indication that things are bogging down, would you communicate with us and with others?

Secretary SCHWEIKER. I would say that if there is any danger of that happening, and I have not heard of any until now, but if there is any danger, we would certainly work with the committee because we think it is a very important program and obviously should not be held up. We would be pleased to work with you on it.

Senator SCHMITT. Mr. Secretary, it has been my impression through the years that the reason the Head Start program has seen a modest, and in some areas even spectacular, success has been the result of the motivation of the individuals who were involved as grantees and that salary and other things have not been as important as the fact that young people generally had an opportunity to work with preschool students.

Do you think that that general environment still exists within the Head Start program, or is it starting to run into problems as some other volunteer-type efforts like the Peace Corps ran into after a few years—more the result of social change than the nature of the persons going into it?

Secretary SCHWEIKER. So far, Mr. Chairman, we have been very pleased with it. This is one of the reasons for the safety net program. As you know, four of the seven safety net programs are in my Department, and this is one of them. I suspect any Federal program after it goes for awhile has some form of old age set in, but we still feel it is performing well. We feel it is effective and really doing a cost-effective job in the area. We have not seen any recent sign that this is happening, but I think we should be on guard because it does happen to a lot of programs.

HEAD START WORKERS

Senator SCHMITT. Any idea of what the average age of the Head Start worker might be?

Secretary SCHWEIKER. The Head Start worker?

Senator SCHMITT. The person working with the Head Start children, compared to what it might have been when the program started. My impression is, when I meet with Head Start people, at least in New Mexico, that they're a relatively young group of individuals which sounds like it's rejuvenating itself. That's just the impression I have.

Secretary SCHWEIKER. I think one problem that is apparent here is that they are relatively young people in terms of teachers because of the pay involved. At early training stages, there is a salary problem, and there has been a turnover rate of about 20 to 25 percent that we attribute to low salaries. So in our budget proposals we are making some provisions to upgrade their salaries to make them more relevant to the needs of the young staff whose salaries have not kept up with the inflation.

So that might be a problem that is creeping in. We are trying to meet it with some increased budget—about 52 million dollars' worth. That includes several things, of which teacher's salaries is one.

AGING BLOCK GRANT

Senator SCHMITT. With respect to the aging block grants, you're proposing consolidation of the separate elderly nutrition programs with the social services programs for the aging. Do you think this consolidation which is intended to provide greater flexibility for State and local agencies will result in more or less concentration on elderly nutrition services?

Secretary SCHWEIKER. Now keep in mind, this is not really a block-grant program in the sense that the others are. We are not turning it back to the States. What we are doing is blocking it to us at the Federal level.

Senator SCHMITT. As a national program. What would be a good term for the contract?

Secretary SCHWEIKER. Consolidation, I guess. Federal consolidation of the program.

Senator SCHMITT. A consolidation block, maybe?

Secretary SCHWEIKER. It is Federal block granting, or Federal consolidation of several programs. We believe it will have the advantage of keeping a national focus and keeping a national centerpiece to it. At the same time, it will give us and the program recipients a little more flexibility in how the program is managed and a little more efficient delivery, but it is all for the elderly, so we feel that priorities will still be there.

ELDERLY NUTRITION PROGRAMS

Senator Schmitt. The elderly nutrition programs have certainly had a lot of popular appeal. You would not, then, expect that to change? They've also provided something beyond just good nutrition for the elderly, at least as far as I've been involved with them in New Mexico. They provide a social environment as well as nutritional environment.

Secretary Schweiker. We believe the fact that it is still a national, more or less single categorical program, we will keep the priority and the emphasis there.

Senator Schmitt. Do you have a figure for the funding for the consolidated program for fiscal year 1982 under the assumption you're making with respect to legislation?

Secretary Schweiker. We have a total for the consolidated programs of $692 million.

Senator Schmitt. And that's a consolidation. The total you have for the Administration on Aging—you said $692 million?

Secretary Schweiker. That's right. It's about a $10 million increase over what our 1981 budget was, and it is about a $50 million increase over the 1980 budget.

Senator Schmitt. That, then, combines the social services, incentives, and the two nutritional programs?

Secretary Schweiker. Nutritional programs, USDA commodity programs, and social service centers for the aging—three programs.

Senator Schmitt. We'll study that a little bit more and work with your staff to make sure we understand it.

Secretary Schweiker. OK.

NATIONAL CITIZENS PARTICIPATION COUNCIL (NCPC) FOR DEVELOPMENTAL DISABILITIES

Senator Schmitt. On March 6, 1981, in a letter of reply to my letter, Mr. Secretary, you indicated that an audit of the National Citizens Participation Council would be completed within a month. Has that audit been completed, and if so, what are its findings?

Secretary Schweiker. The investigation of the $490,000 award commenced shortly after September 29, 1979, through an Inspector General hotline complaint. The subsequent audit after the initial investigation was started is now completed and a final audit report is being prepared. It's findings will be reviewed by the Inspector General's Office of Investigation and a determination will be made as to what additional investigation is required.

Because of your interest, I have requested that this matter be given top priority. In fact, I have spoken to the Acting Inspector General about it. But they are under notice from me that they are supposed to have it completed as soon as possible, so we will have it available soon.

Senator Schmitt. We'll look forward to that communication. When do you think it will be ready, another few weeks?

Secretary SCHWEIKER. I think a month would probably be more like it, Mr. Chairman.

Senator SCHMITT. OK. We then will expect that in a month.

REFUGEE SETTLEMENT SOCIAL SERVICES

The administration is proposing a rescission of $4 million for refugee social services in fiscal year 1981. The committee understands that this money would have been spent on demonstration projects to try to make refugees less reliant on cash assistance and self-sufficient at the earliest possible date.

Why has the rescission been requested?

Secretary SCHWEIKER. This was money that was spent on special project work such as national conferences. I think it was some $4 million that was spent on conferences, meetings, and our analysis of it was, it was not very productive. It just did not bear any fruit, and it was not good utilization of refugee money. That is why we requested the rescission.

Senator SCHMITT. The demonstration projects really weren't demonstration projects.

Secretary SCHWEIKER. Right. They were conferences, meetings, and things like that. And that is why we recommended the action that we did.

Senator SCHMITT. Mr. Secretary, do you see an inherent difference in the society today with respect to political refugees than, say, it was 50 years ago? Is it much more difficult for a political refugee now to assimilate within our society than it was 50 years ago?

Secretary SCHWEIKER. I think that it is probably more difficult today than then because of the population of the country, because of the inflation situation, and because of the recent influxes that we have just had in the last few years. So I would see a difference, yes.

NEW FEDERAL ASSISTANCE

Senator SCHMITT. Do you think, then, that Federal assistance is going to be required where it wasn't 50 years ago?

Secretary SCHWEIKER. In our budget process initially there was a reduction in the Soviet refugee portion of the budget. I appealed that decision and we had that reinstated, so we believe that that should be adequate, given the current rate of the Soviet refugees. That has been restored, and we presently believe it will be adequate for the rate of people leaving the Soviet Union.

On the other refugees, Cuban and Haitian, we are not budgeting money for another significant influx of Cuban refugees. If that happens, we will have to come back to the Congress and ask for additional money.

Secretary of State Haig has made it very clear that we take, with great concern, any movement by Castro to use refugees as an instrument of national policy against us, and we have put him on notice to this extent.

We have not put money into the budet for that contingency. If that contingency does happen, we will have to come back to the Congress and ask for more money to deal with it.

Senator SCHMITT. What initiatives do you have to try to move the refugees out into the private sector and away from cash and medical assistance maintenance by the Federal Government?

Secretary SCHWEIKER. Well, one of the problems right now has come at Fort Chaffee, where we have some 3,000 to 4,000 refugees that are the remnants of the last Cuban exodus. We are in the process now—I am on a task force with the Justice Department that it shares—dealing with refugee policy in cases such as this, and we are in the process of formulating what to do to dispense with those who remain.

One of the problems is that after we do what we can to get them out into the country, there will be some people remaining who have criminal records of a very severe nature and who have mental problems of a very severe nature. We are wrestling with that because we do not have any legal basis to detain these people at present. Their status is quite undefined in the law.

On the actual assimilation we have done very well. We have gotten private agencies, contracted with them on a per capita basis to assimilate them, and I think we pretty well know the agencies that have been successful. It does take dollars, though.

So every time there are refugees, we figure we are going to need the dollars to assimilate them. What we have not solved though are those situations where their legal status is uncertain and they are incarcerated. That is really a tough problem and I am working with the Attorney General right now and the task force to see what we can do about it.

SUBMITTED QUESTIONS

Senator SCHMITT. Thank you, Mr. Secretary. You'll keep the committee informed as you and the Attorney General reach some conclusion on that? I realize it's a tough one.

We'll have many additional questions for the record and ask that these be provided at the same time you return the corrected transcript.

[The following questions were not asked at the hearing but were submitted for response for the record:]

Questions Submitted by the Subcommittee

Question:
Please describe for this Committee how the block grant concept would operate. Will there be a maintenance of effort required? Will existing projects have any protection, at least in the first year of operation?

Answer:
The Federal government will make annual grants to states and territories to support the services identified in the block grant legislation. Within the general purposes of the block grants, states will make their own decisions about how to use the funds (i.e., which services to provide and which populations to cover). The federal government will not earmark funds for particular services. These funds must be spent for the purposes of the programs that were consolidated to form the blocks, and not for other purposes. However, states may transfer up to 10 percent of the funds from one block grant to any other block grant received from the Department of Health and Human Services. A state's grants will equal approximately 75% of the total funds received for these services in fiscal year 1981 by the state and the entities within it. States must publicize their plans for spending the funds prior to any expenditure. States must also report to their citizens on how the funds were used and must arrange for an independent audit of expenditures at least every two years.

No matching or maintenance of effort requirements will be imposed.

States will determine the activities that will be supported with block grant funds. As a part of this they will make all decision on the continuation of existing projects currently funded directly by the federal government.

Question:
Do the states presently have the capacity to administer the block grants effectively and efficiently? Will they on October 1, 1981?

Answer:
States currently are the recipients of approximately 75% of the funds included in the block grant and thus are already heavily engaged in administering the services that are to be supported by the block grant. A major purpose of the block grants is to clarify the responsibility of state government to make the basic choices on the health and social services supported by the blocks. This clarification of accountability of state government to its citizens will promote

efficient and effective service delivery and increased state administrative capacity.

Qusetion:

Why do you feel that it is better to set up 50 separate state bureaucracies instead of continuing, one already established, federal bureaucracy?

Answer:

The block grants do not set up 50 new state bureaucracies. Instead of increasing bureaucracy, block grants will lead to better organized administrative systems at the state level. Under the current categorical system, it is difficult for states to establish a coordinated system because of the many different programs and because of direct federal funding of a large variety of organizations in the state.

Question:

If this Subcommittee, through report language, directed HHS to make certain the states are adequately geared up to administer the block grants, how would you proceed?

Answer:

States already are administering 75% of the funds incorporated in the blocks and therefore administrative systems are already in place. Nevertheless, to ensure a smooth transition, we will be working closely over the next few months state governments and the national organizations that represent them.

Question:

Is the $500 million reduction entirely administrative savings, or will there be real cutbacks in services provided?

Answer:

We believe that the reduction will be significantly offset by administrative savings in three ways. First, administrative costs for categorical programs average roughly 10%. Elimination of federal red tape and federal reporting requirements and in some cases requirement for separate bureaucreacies will result in considerable savings in these costs. Second, consolidation of these programs will allow states to improve and streamline their service delivery systems, and to reduce overlap and duplication. Finally, the increased flexibility of the block grants will allow states to direct resources to the highest priorities within each state, thus increasing the overall effectiveness of each state's investment in health and social services.

Even after these savings, however, some states are likely to have less money available for services. This will, of course, vary substantially by state and depend to a great extent on how quickly states can take advantage of the administrative flexibility allowed by the block grant legislation.

Question:

Do you expect state and local management expenses to increase proportionately?

Answer:

No. State and local governments are already heavily engaged in providing the services that are to be supported by the block grants. Many federal requirements will be eliminated (e.g., federally specified state plans and lengthy reports); thus, state and local government management staff will be free to devote their time to planning and managing services rather than filling out papers for submission to the the federal government and ensuring compliance with varying federal requirements.

Question:

The programs proposed for block grants are purported to overlap and duplicate other programs in services provided and/or population served. Do you agree? Can you provide us with some examples? Why were these overlaps allowed to occur in the present system?

Answer:

Some of the current programs are overlapping. An example is family planning. Funds for family planning are provided by four of the programs consolidated in the blocks--title X (family planning) and title V (maternal and child health) of the Public Health Services Act, the adolescent health program and the community health centers. Overlaps such as this have occurred because each program has had a slightly different focus (e.g., target group, kinds of services provided). States will now be able to decide who they want to serve and what kinds of services they will provide.

Question:

To what extent would block grants make services provided more accessible to individuals in need? Can you provide us with examples? In competing for block funds, are you convinced that the poor and the needy can have at least an equal voice on the local and state level as they have had on the national level?

Answer:

States are better able than the federal government to determine which of their citizens are most in need. Under the proposed legislation, states will prepare and make public pre and post-expenditure reports on what services the block grants will be used for and who will be served. Citizens of a state will have an opportunity to review how states will (and did) operate their programs and to make their views known directly to their state legislatures.

Not only will states be able to focus on the services that are of highest priority in the state, but they will also be able to provide those services in a more efficient manner. This will improve access to services through effective coordination of supporting services, such as information and referral and transportation.

Question:

Are you recommending funding floors and ceilings for the various categories within each block grant? What other guidelines and requirements will be provided to the states in distributing block grants, to ensure adequate funding in all categories? What restrictions, if any, will be placed on block grants in terms of what the funds can be used for?

Answer:

We are not proposing any floors, ceilings or spending guidelines for funding the various categories of services in each block grant. The purpose of the block grant is to enable states to make decisions on what services to provide and how best to provide them. Thus, we have placed minimal restrictions on the use of block grant funds by the state. These include: purchase or improvement of land or the purchase, construction or permanent improvement of any building, except in extraordinary circumstances; matching by states of other federal programs; cash assistance payments for the health block grants and social services block grant (with some minor exceptions); payment of salary of any individual as a social service; social services in large institutions (except rehabilitation); provision of medical care in the social services block grant unless subordinate to a social service; and public education (other than information and referral or rehabilitation services) in the social services block grant.

Question:

Under block grants, will the local program managers be held accountable for mismanagement and inefficiency by the state or by the federal government, and will case referrals go to the state departments of justice or to the federal Department of Justice?

Answer:

Funds must be used for the purposes set out in the block grant and are subject to both state and federal audit to ensure that the expenditures are in accordance with the block grant purposes and other federal statutes. However, we intend to rely principally on independent audits of expenditure of funds by the state. In addition, the block grant funds are subject to state laws appying to expenditure of funds. Mismanagement could result in suspension of federal payments or civil or criminal action based on federal or state law, depending on the circumstances.

Question:

What would you recommend to the Committee as an alternative in case the block grant authorization isn't enacted before the Subcommittee marks up the Labor-HHS-Education bill?

Answer:

We anticipate timely passage of the authorizing legislation, and thus are asking the Appropriations Committees to appropriate money for the block grants in anticipation of their enactment prior to the beginning of Fiscal Year 1982.

Question:

Please provide a state by state run down of how states are administratively and programmatically geared up to handle block grant money.

Answer:

We expect to have within several weeks such a run-down. The Department is now working with the National Governor's Association, the National Conference of State Legislatures and the individual states to identify and resolve any short-term transitional problems. Given the flexibility allowed by the blocks, all states have adequate administrative capacity to handle the additional responsibilities.

Question:

Why do the blocks provide for a 10% transfer of funds from any one of the four grants to another one? Doesn't this further dilute the support of various grant-in-aid programs that face reduced funding under the block grants?

Answer:

The transfer provision allows additional flexibility to ensure that spending is in accord with state priorities.

Question:

To what extent will the block grant for social services not require that spending be based on need or income?

Answer:

The Social Services block grant has no provision requiring that services be allocated on the basis of need or income. The states may, however, do this, and we expect that many will. The states are in the best position to determine who is most in need of particular services, and to establish eligibility requirements for the programs and services they administer.

Question:

Would any requirements for quality standards and even citizen participation be omitted from such a block grant?

Answer:

The proposed block grant legislation requires that states make public pre-expenditure plans at such a time and in such a form as to stimulate public comment. Post expenditure reports also are to be made public. We do not establish, however, any quality standards.

The states have the flexibility to establish such standards, as well as precise mechanism for citizen participation, or other requirements that they determine are appropriate for operation of these services.

Question:

Aren't block grants too flexible, just amounting to another form of revenue sharing?

Answer:

In one sense, all federal assistance programs are forms of revenue sharing. The block grant legislation however, targets federal assistance on particular kinds of services, such as preventive health services. The funds cannot be used for other purposes.

Question:

By "blocking" various categorical programs, aren't you creating potentially destructive competition between the groups covered by the various categorical programs? Aren't your block grants likely to, "pit families against the elderly, handicapped advocates against parents concerned about child care?"

Answer:

The block grants place with the state the responsibility for determining what services are needed and who receives them, much as is now done under the social service program established by title XX of the Social Security Act. The Governors and state legislators will determine state priorities. Competition for limited funds is a part of every budget process, federal state or local. Those who wish to seek funding for particular services will have to direct their attention to the state budget and legislative process. This process is better able to ensure an appropriate balance of service priorities than is the current federal categorical system.

Question:

What safeguards have you included in your block grant proposals for monitoring state and local distribution of funds? How can you ensure against local politics in the distribution of block grant funds?

Answer:
The block grants do not provide for federal monitoring of the distribution of funds by the states, but rather make it clear that the states are accountable to the people in the state. We believe that the state budget and legislative processes are positive forces for determining state service priorities and ensuring their relevance to state needs.

Question:
Why do you think there will be reductions in losses due to mismanagement, inefficiency and systems problems as a result of state management of block grants?

Answer:
States currently administer 80 percent of the funds for the programs consolidated in the blocks. Under the blocks, states have greater flexibility than they now have to utilize more efficient systems and administrative techniques. It will be to the advantage of the states to ensure proper management of funds and to develop efficient management systems. They will want to maximize their resources so as to provide more services to meet the needs of their citizens.

Question:
On what does the Department base the assumption that fraud and abuse which exists at the federal level would be reduced with the consolidation of many health and social service programs into block grants to states and localities? Is there any basis for concern that consolidation may merely result in the transfer of fraud and abuse to the state and local levels?

Answer:
Consolidation will enable states to exercise maximum control over the management and administration of their programs. States will have primary responsibility for expenditure of the funds and be accountable to the residents. Accountability at the state level rather than confused accountability under the categorical programs will be a positive force in controlling fiscal abuses. In addition, states will have to make pre and post-expenditure reports available to the public, as well as have an independent audit not less often than every two years.

Question:
How will the Department assist the states and localities in minimizing the incidence of fraud and abuse in the administration of health and social science programs under the block grant approach?

Answer:
States have the primary responsibility for designing management systems which identify

and correct fraud and abuse. However, the federal government will continue to identify innovative and effective ways to combat fraud and abuse, and make this information available to the states. Other forms of technical assistance will also be available as requested by the states.

Question:

How will the Office of Inspector General and the Office of Civil Rights fit into a consolidation plan? Do you expect the roles of the office of Inspector General and Office of Civil Rights to change substantially with the enactment of block grants?

Answer:

Both offices will continue to discharge their existing responsibilities.

Question:

Will it be a civil rights issue if states do not allocate funds from the block grants to "minority" segments of the population, such as blind, mentally ill, poor, and so on? Please comment.

Answer:

Each of the block grants contains nondiscrimination provisions that prohibit states or their grantees from discriminating on the basis of race, color, national orgins or sex in the provisions of services funded by the block grants. Additionally, the block grant legislation expressly recognizes the application of section 504 of the Rehabilitation Act of 1973--which prohibits discrimination against qualified handicapped persons--and the anti-discrimination provisions of the Age Discrimination Act of 1975. The federal goverment will enforce these provisions.

Question:

Why were no limitations placed on such items as rental costs and administrative overhead?

Answer:

There are three reasons. First, each state will have differing rental costs and administrative overhead and it is difficult and inefficient to establish a single limitation that would fit all states. Second, there are sufficient incentives in the improved accountability aspects of the block grants to minimize administrative costs. Finally, federal red tape to monitor these costs would be burdensome and of little practical value.

Question:

Would you support any limitations on salaries of state and local officials in the various programs?

Answer:

No. States should have the responsibility for setting salary policies for state officials and their grantees.

Question:

How can you keep the state program people in their jobs so they can run the "blocks" at the state level? How can you protect them from being fired by state administrators?.

Answer:

State personnel policies are, and should be, exclusively a state concern. We do not expect, however, that states will summarily discharge people who are currently administering programs that are blocked.

Question:

Does the Administration expect states to continue rehabilitation training programs, client assistance projects, projects with industry, independent living centers, spinal cord injury model centers, severely handicapped projects, and others now administered through the Rehabilitation Services Administration? If so, how could consistency in, and overall policy for, these programs be maintained?

Answer:

We do expect that the states will continue rehabilitation services-related activities. The social services block grant will allow services to the same target groups and special populations as the programs being consolidated.

States will have the authority to continue services, consolidate or expand them as they deem necessary. The point of the block grants is that these decisions will be made at the state level and reflect state priorities. There is no need for national consistency in the support of these services.

Question:

Since the federal training program is the only source of funds for training many rehabilitation professionals, what mechanism would be available to insure a flow of needed profesionals into those critical fields, such as rehabilitation teaching for the blind, orientation and mobility training, and others?

Answer:

States will receive, as a part of the Social Service block grant, the training monies which were previously authorized under the Rehabilitation Act. States will be given information as to which training programs are now being funded, their purposes, and their funding levels. In addition, it is believed that states will pay for necessary training since it is in their best interest to have appropriately trained personnel.

Question:
How can programs for blind people be protected if total flexibility is given to the states through block grants, particularly when this is coupled with a 25% cut in funding?

Answer:
States will have the authority and resources to provide services for persons who are blind. We believe that the states are sufficiently sensitive to the needs of the blind that they will continue to make the necessary resources available. States are in a better position to accurately assess the particular needs of all handicapped persons and to develop a delivery system which can coordinate all needed services and provide them in the most efficient manner.

Question:
The reason for establishing all the categorical grant programs administered by ADAMHA was because states and localities had done so little in these areas. What assurances do we have that lump sum block grants will be used to address these problems if given to the state?

Answer:
States and entities within states currently spend substantial funds on mental health, drug abuse and alcohol services. We expect that to continue, but the amount or proportion of the blocks devoted to these services will vary by state.

There is no requirement under the block grants that funds be spent on the services currently funded by ADAMHA. We do not expect major cutbacks, however, the purpose of the block grants is to allow states to determine which services to provide.

Question: In my State of South Dakota, HMO feasibiltiy studies been authorized by the Department of Health and Human Services even though the appropriate State and local entities who are supposed to have input in this process have opposed such studies. Would you please comment?

Answer: In the past 3 years, the Office of Health Maintenance Organizations has funded two HMO grants to organizations in the State of South Dakota. The appropriate Health Systems Agencies voted to approve one and to disapprove the other. This latter decision was made on a grant application in FY 1980.

Both the National Health Planning and Resources Development Act and the implementing regulations spell out specific criteria an HSA is to use in reviewing an application for grant funds.

In deciding to award the grant application last fiscal year, the Department carefully considered the HSA comments. The decision to overrule the HSA and award the feasibility grant was based on:

1. The fact that the HSA applied criteria other than those to which they are restricted by law and regulations in reaching their decision; and

2. The fact that the reasons put forth by the HSA in disapproving the grant application are the exact things which the feasibility study is intended to prove or disprove.

The area to be served by the proposed HMO was both nonmetropolitan and medically underserved. Both of these are designated in the Public Health Service Act as priority areas for the awarding of HMO grant funds. The Department believed, therefore, that the grantee should be given the opportunity to determine if an HMO was feasible in the proposed service area.

Question: Do you plan to disband the current three institutes, NIAAA, NIMH, and NIDA when the service component is moved to the block grant? What will become of the training aspect within each institute? What will happen to the research components?

Answer: We have no plans at this time to modify the current organization structure in the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). As you know all three institutes - National Institute for Alcohol Abuse and Alcoholism, National Institute of Mental Health and National Institute on Drug Abuse - as well as ADAMHA are prescribed in statute and any changes will require consideration by the Congress.

Our 1982 budget requests for each of the three institutes reflects our intent to continue to support research and the training of researchers in order to understand the causes of and treat alcoholism, drug abuse and mental illness.

INCENTIVES TO STATES FOR HOSPITAL RATE SETTING

Question: Eight States now set maximum rates for hospital charges. According to the CBO, these ceilings have been effective in restraining hospital costs even though the States only received an average of about 11 cents out of every dollar saved -- principally in the form of lower Medicaid payments. The Federal government benefits to a far greater degree in the form of lower costs under Medicare and the Federal portion of Medicaid. Would you favor giving the States a greater financial incentive to control hospital costs by allowing them to retain a greater percentage of any savings?

Answer: HHS has been actively supporting States in their efforts to contain hospital costs through the use of rate-setting programs for a number of years. This support takes the form of either research development grants and/or reimbursement waivers.

However, while mandatory State rate-setting programs appear to have had some success in reducing the rate of increase in hospital costs, the evidence at this time is preliminary and inconclusive. Therefore, I believe the research data does not support a rapid, immediate expansion of Federal financial support as CBO has suggested.

Moreover, if the Administration's proposed cap on Medicaid expenditures is enacted, States should have adequate incentives to control hospital costs in the future. As far as Medicare is concerned, it would be unwise to make new Federal commitments in this area without first examining how State rate-setting programs fit into the Administration's plan to contain health costs through a pro-competition strategy.

PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

Question: Mr. Secretary, why are you proposing to close the Public Health Service Hospital and Clinic System?

Answer: The Administration's proposal to eliminate Department of Health and Human Services support for the Hospital and Clinic System is predicated on the disentitlement of the merchant seamen. Free medical care at public expense for this select population is both inequitable and unwarranted. Once entitlement to medical care for the merchant seamen is discontinued, there is no economical reason for keeping the Public Health Service Hospital and Clinic System open. Occupancy rates of the hospitals have averaged about 67 percent since 1976; the majority of this occupancy, 41 percent, is made up of merchant seamen.

Question: What percentage of these people have medical coverage of their own?

Answer: We estimate that a minimum of 23 percent of the merchant seamen have some type of health insurance. We understand, however, that their insurance premiums are low as consideration is given to the fact that they have medical care entitlement through the PHS Hospital and Clinic System. To our knowledge, the Public Health Service Commissioned Corps, the Coast Guard, and National Oceanic and Atmospheric Administration active-duty personnel depend entirely on the PHS or their sponsoring agencies for medical care needs.

Question: If the merchant seamen's entitlement is not repealed, would you still plan to close the system? Why or why not?

Answer: A decision to close the hospitals and clinics, should Congress continue entitlement to health care for the merchant seamen, would need to be reexamined and no definite decision has yet been made.

PUBLIC HEALTH SERVICE HOSPITALS - LANGUAGE

Question: According to your justifications, you want the Appropriations Committee to change the law so you can begin shutting down the PHS Hospitals in 1981. Why don't you go to the authorizing committees for this legislative change?

Answer: While there is also a legislative proposal pending to amend the law, using the proposed appropriations language would expedite the process.

Question: If the authorizing law isn't changed at this time, do we do nothing in regard to the FY 1981 appropriation for the hospital and clinic system?

Answer: If the proposed appropriations language or amended legislation is not enacted, it may be necessary to continue the PHS hospital and clinic system at current levels until legislative changes are made.

Question: How much should we appropriate for FY 1982 assuming no immediate change in the authorization?

Answer: The Administration would need to reexamine the appropriations level required when it is determined that legislative changes will not be made in time to act on the Administration's current appropriations request.

ALTERNATIVES TO PUBLIC HEALTH SERVICE HOSPITALS

Question: In the President's Program for Economic Recovery, alternatives for the use of the Public Health Service facilities are mentioned. Have any communities or other facilities agreed to take over the Public Health Service workload?

Answer: No agreements have been made, as yet, to transfer the hospital and clinic workload to other facilities.

Question: Have there been any proposals from communities to take over the hospitals?

Answer: Currently, we have no proposals from communities interested in taking over the hospitals.

BUDGET COMMITTEE PROPOSAL

Question: As you know, the Senate Budget Committee is proposing to add $18 million to help communities to take over the hospitals. Is there any legislation that would allow us to do this if the money is added?

Answer: The Department envisions providing the bulk of its support prior to the physical transfer of these facilities. If support is required beyond the date of transfer, it may be desirable to enact special legislation, or alternatively to utilize the general provisions of Title III of the Public Health Service Act.

Question: Is any such legislation being proposed?

Answer: The Administration has not proposed any legislation for this purpose at this time.

NATIONAL HEALTH SERVICE CORPS

Question: Your budget is requesting a field strength of 2,500 assignees in 1982. What is the plan for the future size of the National Health Service Corps?

Answer: Our current projection of a 2,500 National Health Service Corps field strength through 1984 is based on the projected supply of physicians and other health care providers as stated in the final report of the Graduate Medical Education National Advisory Committee which concluded that there will be 70,000 more physicians than required by 1990; most specialties will have a surplus; and the primary care fields of osteopathic general practice, family practice, general internal medicine and general pediatrics will be in balance by 1990, but they could develop a surplus in the 1990s.

Question: What are the retention rates for scholarship recipients entering the NHSC and the retention rates for volunteers?

Answer: In 1979, of 103 scholarship assignees eligible to terminate their assignments, 27, or 27 percent, extended with the Corps or converted to private practice in Health Manpower Shortage Areas (HMSAs). Of 457 volunteer assignees eligible to terminate their assignments, 272, or 59 percent, extended with the Corps or converted to private practice in HMSAs.

Question: Why are you phasing out volunteer recruitment?

Answer: With the number of scholarship recipients currently in the NHSC Scholarship pipeline, there will be adequate numbers of providers to satisfy the manpower needs of the highest priority health manpower shortage areas. This is the most critical need of the NHSC at this time.

Question: What is your future policy on volunteer recruitment into the National Health Service Corps?

Answer: For the immediate future, the Department will not be recruiting volunteers to serve in the National Health Service Corps. However, the Department will continue to provide placement assistance to volunteers interested in practicing privately in shortage areas.

Question: Why have you now so drastically lowered your estimates of the need for NHSC personnel compared to earlier estimates of need provided to Congress?

Answer: When the National Health Service Corps was originally started, it was projected that the necessary field strength of 9,000 would be attained by 1990. With the increasing supply of physicians and other health providers, however, there is evidence that physicians on their own accord are beginning to settle in some of the more rural areas of this country and that competitive forces alone will solve some of the distribution problems. By the same token, there is equally strong evidence that some areas of this country are sufficiently undesirable that health care providers will not willingly locate there and as such the NHSC becomes the principal Federal mechanism for assigning health professionals to these localities.

With a current field strength of 2,060, it was felt that until a further determination could be made regarding the effects on distribution of a still increasing supply of physicians and efforts to identify alternative methods for placing health providers, such as private practice and non-direct federally supported sites, the NHSC should not increase beyond a field strength of 2,500 in 1982.

Question: What are you doing to encourage the use of the Private Practice option?

Answer: Communication continues to be the main means of encouraging the PPO. In addition, we are supporting the following activities to encourage the PPO: site visits for scholarship recipients; provision of contractual technical assistance to aid in PPO site development; and work with national organizations, such as the American Hospital Association, the American Group Practice Association, the Hospital Corporation of America, the American Medical Association, and the Adventist Hospital Association of America, to identify PPO vacancies.

The Administration is also considering special incentives to encourage the private practice option, and its legislative package will speak to this point.

MATERNAL AND CHILD HEALTH

Question: The Maternal and Child Health program is proposed by the Department for consolidation into the basic health care block grants. The Research and Training program is proposed for termination. The Department in its justification indicated that research and training funds were available within other agencies of the Public Health Service. Have you specifically earmarked research and training for this program in the budget?

Answer: Funds have not been earmarked for Maternal and Child Health (MCH) Research and Training. The rationale for terminating the MCH Research and Training programs is that other agency programs presently engaged in health research and training are adequate to support functions that ultimately benefit the MCH research and training activities.

Question: What amount is being allocated for this specific function?

Answer: No funds have been allocated for Maternal and Child Health Research and Training. We are hopeful that projects will be able to secure support through State or local sources, as well as through private foundations and like organizations.

COMMUNITY HEALTH CENTERS

Question: This month the General Accounting Office issued a draft report on the Community Health Centers program which identified many inadequacies in the Department's administration of this program. Specifically, GAO states that:

1) HHS had not given grant applicants adequate guidance and criteria to help them meet the legislative requirement of assessing the need for health centers in medically underserved areas.

2) Medically underserved area designations were not updated to reflect the most current data available. Data sources being used were 7 to 11 years old.

3) HHS grant reviews were inadequate.

4) HHS relies heavily on the medically underserved area designation of the proposed service area which was developed essentially as a gross indicator of need, rather than a specific measure of need at the community level.

What is the Department doing to evaluate the validity of the criteria used to designate medically underserved areas?

Answer: The Department regards the Index of Medical Underservice as a valid gross screen to identify potentially Medically Underserved Areas. This perception has been confirmed by two studies (Kleinman at the National Center for Health Statistics and Aday at the University of Chicago).

After identification of an area as Medically Underserved, the Department has relied upon local and State planning processes to assure compatibility with needs and assessments contained in health systems plans.

Question: What specific criteria is being developed by the Department to provide prospective grantees specific guidance on how to perform and what should be included in needs and demand assessments for the program?

Answer: Because the process has not worked as well as we had hoped, the Department is currently developing a methodology for assessing community-level need for primary care, to be performed as part of the grant application and review process. It will supplement the existing MUA process by providing a more detailed look at health needs and health resources, including contiguous area resources.

Question: What is the specific timetable for updating future medically underserved area lists that would consider current data as they become available?

Answer: We plan to incorporate the 1980 Census and other data into the MUA process according to the following schedule:

An MUA list incorporating 1980 census data would be ready for review prior to final publication on approximately December 1, 1982. The time and task analysis is outlined below:

					1982				
TASK	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV
Receive National tapes for full sample counts	X								
Order physicians (AMA&AOA) data tape		X							
Order Infant Mortality data		X							
Reblock BCHS geofile & census files for compatability		X			X				
Enter all data files					X	X			
Apply test runs					X		X		
Clean-up						X		X	
Score IMU for Nation								X	

	1982								
TASK	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV
Set MUA cut-off score and produce proposed list									X
Compare to official MUA list and BCHS Project Service Area file to obtain effect on BCHS programs									X

Question: What policies and procedures are being proposed by the Department to ensure that grant applications are adequately reviewed and meet the established criteria for a medically underserved designation?

Answer: The Department is in the process of reviewing all policies and procedures with respect to grant applications in light of the Administration's proposal to include 25 health programs in a block grant proposal. These policies and procedures will have to be tailored to the nature of the block grant.

Question: If an area is no longer considered underserved, what is your policy toward continued funding for Community Health Center projects it contains?

Answer: The Bureau of Community Health Services (BCHS) is concerned that Community Health Centers serve only the truly needy and that Federal resources are provided only to those areas which still lack private sector medical care.

Accordingly, in 1981, BCHS has undertaken three efforts to identify areas which are no longer underserved. Projects in those areas will be terminated:

1) Areas which were designated Medically Underserved Areas (MUAs) solely because they were Health Manpower Shortage Areas. (Nineteen projects currently face defunding for this reason.)

2) Areas which are deleted from the MUA list as the result of updated data.

3) Projects which serve areas where the majority of the population is not medically underserved.

In 1982, it is anticipated that the flexibility inherent in the Administration's block grant proposal will permit States to shift funds to the most needy populations as determined by State officials.

Question: What are your thoughts on reducing the level of the grant after a center has received Federal funds for a reasonable period?

Answer: This decision is best made on a case-by-case basis. The Administration's block grant proposal will permit States to make decisions about reducing grant support on whatever basis is deemed appropriate by State officials.

MEDICALLY UNDERSERVED AREAS

Question: Year after year we have been told by the Department that there are 20 million people in medically underserved areas. Is this still correct?

Answer: Yes, there are approximately 20 million people residing in high poverty areas who lack access to private sector medical care. Approximately 5 million of these people are served by primary health care centers.

Question: How will the block grant proposal insure that these people will receive services?

Answer: We cannot insure that the block grant will continue to provide services to these people. However, we are hopeful that the States will utilize the block grant resources to continue services for the most needy persons residing within the States.

Question: A recent report published in The New England Journal of Medicine* indicated that more physicians are beginning to locate in smaller towns. For example, the study shows that in 1970, only 9 percent of small towns with populations between 5 and 10 thousand had a specialist in internal medicine. By 1977, the percentage had jumped to 23 percent. Similar gains were recorded in other specialties. Moreover, with all the new doctors coming out of our medical schools, it is expected that even more doctors will be setting up practice in smaller towns in the years ahead.

Since market forces seem to be taking care of the geographic distribution problem, why can't we begin to phase out the Community Health Center program?

Answer: The Department of Health and Human Services has been monitoring the trends of physician locations. We are concerned that primary care centers are located only where they are needed as providers of last resort, either because other health resources are not present or because other providers do not accept poor or Medicaid patients.

The Rand study shows, as we would expect, that the market seems to work for medium-sized rural towns, but not for the poorest or most rural areas. As an editorial in Annals of Internal Medicine (June, 1980) noted, "Rural and underserved are different concepts that should serve as proxies for each other only rarely. Fifty-five percent of Americans live in communities of less than 25,000 population, but it is the six percent in medically underserved rural America ... that feel the physician shortage most critically."

These poorest and most rural areas are not generally benefitting from the increasing physician supply. According to American Medical Association data:

1) Between 1971-1977, the physician/population ratio improved 14.1 percent for the total population. However, for those living in the most rural categories of counties, the increase was 4.5 percent.

2) Despite increases in the supply of specialists, more than 40 percent of all rural counties still do not have a medical, surgical or other specialist practicing in their county.

3) In high poverty areas, the physician/population ratio increased from 68 physicians per 100,000 to 74 physicians per 100,000 population, compared to 200 per 100,000 for the nation as a whole.

4) In 1977, counties with more than 20 percent of the population below the poverty level averaged 15 surgical specialists per 100,000 population, while less poor counties averaged 35.

The Rand study adds to our understanding of some of the economic forces at work in locating rural physicians. (Note: The study does not address inner-city areas.) However, an accompanying editorial in The New England Journal of Medicine cautions that personal and professional factors affecting physician location choices are very complex, and adds "a purely economic interpretation of these trends is premature. We need a much better understanding of all factors determining the choice of specialty and location and the characteristics of practice."

A recent review of over 100 studies of the factors affecting physicians' location decisions points to these complexities. Physicians often avoid poor and rural areas because of professional isolation, 24-hour duty, and lack of opportunities for continuing education, as well as for economic reasons. Presence of an organized practice such as a community health center improves the probability of a poor or remote area's attracting and keeping physicians.

These findings are consistent with those of a recent Public Health Service study, "Hierarchical Patterns in the Location of Physician Specialists Among Counties," which shows that higher-order specialists rely on a broad base of less specialized physician types for support, and thus should not be expected in an area unless an adequate physician base is developed.

However elegant the design of these national studies, their application and relevance to local situations must be tempered by a knowledge of special factors at work in the community. Freedom from Federal criteria and standards, based on national norms, will permit States to shift resources according to local conditions.

NURSING LOANS

Question: We note you propose to terminate the Nursing Loan program which presently is running $13.5 million. In your justification you state that "concern is shifting to problems related to the distribution of nurses and the retention of trained nurses in their profession." How is this concern being manifested?

Answer: The Department is currently supporting a study with the Institute of Medicine which will examine several issues associated with the nursing profession. A major area of study will involve the problem of nurse retention and how low salaries and poor working conditions, where they exist, can be improved. The study was authorized by the Congress and is now in the initial stages of development. It is scheduled for completion in 1983.

Question: What programs do you plan to help keep trained nurses on the job?

Answer: At the present time, no programs are planned for this purpose. The Department's two-year study with the Institute of Medicine will address conditions leading to poor retention of nurses and steps which may be taken to improve retention.

FEDERAL EMPLOYEE HEALTH

Question: You are asking about $1 million for the Federal Employee Occupational Health program, which apparently advises government agencies on setting up health clinics on their premises. Why is the Health Services Administration involved in the responsibilities of other departments and agencies?

Answer: The Division of Federal Employee Occupational Health had its genesis in P.L. 79-658, August 8, 1946 now codified under 5 USC 7901. Under the Act, the Public Health Service is assigned responsibility to provide consultation to Federal agencies which are obligated to request such consultation prior to beginning their occupational health programs; when requested to do so, to review the health service programs being conducted by any Department or agency under the authority of the Act of 1946 and to submit appropriate comment and recommendations.

On June 18, 1965, the issuance of OMB Circular No. A-72 established a progressive revision of Federal policy toward occupational health programs for Federal employees. The new policy assigned promotional responsibility to the Civil Service Commission. This resulted in aggressive actions on the part of CSC to urge agencies to plan for occupational health programs as a matter of sound personnel management and an effective means for conservation of personnel resources.

It should be pointed out that approximately $250,000 of the $1 million is to operate DHHS programs, (i.e., Employee Counseling Service programs).

Question: Can't we turn over this role to the departments themselves and abolish the Federal Employee Health agency?

Answer: It would not be feasible to turn this program over to the "Departments" which do not have the medical expertise in the field of occupational health. One hundred twenty-nine (129) of 157 health units of the employee occupational health programs operated through 2,500 individual interagency agreements by DFEOH are in multi-agency locations (Federal buildings) with an average of 12 agencies participating per program (or as many as 60). The majority of these agencies do not have medical branches or components such as the PHS, VA, or Defense Department that could take over the operations of an occupational medical service.

Of the 29 single-agency health units, there are 9 operated solely for DHHS employees, and the remaining 20 generally do not have medical departments.

To turn this role to the "Departments" would not be in the best interest of economy nor to the clientele served.

BUREAU OF COMMUNITY HEALTH SERVICES PROGRAM SUPPORT

Question: Mr. Secretary, all departments and agencies of the Federal Government are being forced to cutback programs and staff in the interests of reducing government spending. Yet, it appears that you have not requested any 1981 rescission for program support under the Bureau of Community Health Services, a $29 million program.

For the time remaining in the current fiscal year, please tell us how much you still can rescind and what the effect will be. Keep in mind: we are looking for the largest rescission possible.

Answer: The Administration proposes no rescission of Bureau of Community Health Services Program Support funding because the Continuing Resolution level of $29 million is the minimum program support level required to operate the Bureau's programs in 1981. For this reason, none of the Bureau's program support funds is available for rescission in 1981.

NATIONAL HEALTH SERVICE CORPS

Question: The Fiscal 1982 request for the National Health Service Corps allows growth of the Corps from 2,060 in Fiscal 1981 to 2,500 in Fiscal 1982, a level to be maintained in subsequent years.

National Health Service Corps 1981 graduates will outnumber existing field corps whose terms expire in 1981. Under the current request, the Department would not be able to grant extensions to the more than 300 doctors with expiring terms, who have requested to stay in the field. These 300 doctors have settled into the communities, gained the confidence of the communities, and learned the language and social structures of the community.

The ultimate goal of the Corps has been to place doctors into underserved communities with the hopes that they would stay and serve that community indefinitely. Doesn't your proposal counter such an achievement?

Answer: Through the expansion of the Private Practice Option, physicians who wish to continue practice in an NHSC site are eligible to do so. Through this mechanism, the goal of having NHSC assignees remain in practice in a health manpower shortage area is met and the Federal payroll for these practitioners is minimized.

Question: What consideration has been given to releasing medical school graduates from their service obligations to enable extension of service to those Corps members who wish to continue their service?

Answer: It is not anticipated that any medical school graduates will be released from their service obligations to the National Health Service Corps. Through: emphasis on the Private Practice Option; a policy of discontinuing in the short term recruitment of volunteers into the NHSC; and through not permitting people now in the NHSC to extend after their period of obligated service has been completed, the field strength of 2,500 is adequate to ensure the placement of all scholarship recipients.

STUDENT ASSISTANCE

Question: We have heard that the Administration's budget cuts will impact upon minorities and the disadvantaged the most. Your budget eliminates funding for exceptional need, as well as health professions and nursing assistance. Will minorities and the disadvantaged be severly hurt by these cuts?

Answer: The Administration's policy of providing assistance to the truly needy continues. Minorities and the disadvantaged will have sources available to them to support their education in the health professions. Both the Health Education Assistance Loan and the Health Professions and Nursing Student Loan programs have revolving funds available in educational institutions to provide assistance to these individuals.

Question: You mentioned that Health Education Assistance Loans (HEAL) will still be available, but Mr. Secretary the cost of HEAL loans is very high. How will students from low income families ever be able to afford this?

Answer: Students from low income families will have other alternatives for loans in addition to the HEAL program.. The Department of Education programs, specifically, the Guaranteed Student Loan program, is available especially to those that have financial need. In addition, the Parent Loan program is available to students from low income families.

Question: Are you phasing out the National Health Service Corps Scholarship program?

Answer: For the immediate future the scholarship program will be gradually phasing down as alternative methods such as loan repayment programs are developed in order to attract people into obligated service in shortage areas.

Question: When do you plan to resume making new awards?

Answer: At the present time, the Department is carefully examining several options with regard to placing obligated health professionals in the NHSC and the role of the scholarship program in fulfilling these objectives is a component of this review.

HEALTH EDUCATION

Question: The Public Health Service has been interested in school health and now the Department of Education has gotten interested in school health, too. How have you and the Department of Education avoided duplication of efforts in school health programs? Have you developed any interagency agreements or made any other arrangements with the Department of Education in regard to school health?

Answer: CDC has worked closely with the Department of Education (DE) in a number of ways to avoid duplication, and assure expert participation. In 1979, that department, then an office of DHEW, was one of five agencies which met jointly to determine the most appropriate placement of administration responsibility for the grants (authorized in Section 402 of the Health Services Amendments of 1978) to deter children and adolescents from smoking and the use of alcohol. Staff of the Department of Education Office of Comprehensive School Health Education then took active part in the formal review panels to rank grant applications for funding under this authority.

In addition, the National Diffusion Network of DE has endorsed two school health curriculum projects developed under CDC contracts as the only health curricula currently included in that network, and DE has provided funding through this diffusion network to help support teacher training in these curricula.

Question: How much money does the Public Health Service spend on health education programs in the schools?

Answer: CDC has awarded approximately $4.5 million of FY 1980 grant funds to support school-based programs to deter children and adolescents from smoking and the use of alcohol. These grants are administered as part of the health education/risk reduction grants to State health departments and awarded by the States to local agencies to support specific approved projects. Every approved smoking-alcohol school-based project was required to demonstrate involvement of local school authorities. In many cases the funds go directly to a local school or school district. In others the local grantee is an agency that works directly with the schools.

Other CDC projects related to school health education do not directly support delivery of school programs, but rather are designed to develop and evaluate school curriculum models and materials and to make available teacher-training and other technical assistance to aid school systems in adopting these models, using funds from other sources.

The Alcohol, Drug Abuse and Mental Health Administration is the other PHS agency involved in health education programs. Over the last seven years, ADAMHA has funded demonstration projects designed to reduce drug and alcohol abuse among adolescents. In FY 1980, the agency, in close collaboration with CDC and the Office of Education (which became the Department of Education), awarded $3.5 million in grants to States and universities to support health education projects demonstrating innovative prevention methods primarily in the drug abuse area. In addition, $2.2 million was awarded in the same year for curricula development. This initiative is to be phased out in FY 1981.

Question: How much does the Public Health Service spend for health instruction programs which are earmarked for upgrading the skills of teachers who have the responsibility to teach health?

Answer: A CDC contract with the National Center for Health Education (NCHE) in San Francisco includes teacher training among its principal purposes. Total funding for this contract in FY 1980 was $620,000 of which about 20 percent is used to upgrade teacher skills, especially among classroom teachers in grades K-7 who lack formal training in health education but include health among their many subject responsibilities. The over-all purposes of the NCHE contract is to help establish a private sector center of expertise in school health; to refine and update curriculum models and materials previously developed under CDC contracts for each of the eight primary and elementary grade-levels; and to encourage and assist in the dissemination of these and other tested school health programs. The National Diffusion Network of the Department of Education works with the same contractor to assist in diffusion of these approved curricula.

BAD HABITS

Question: It seems that many of the health problems that CDC focuses on are self-inflicted and can be attributed to: smoking, bad diet, excessive drinking, soft drug use, hard drug use, driving at high speeds, sexual carelessness, tooth care neglect, lack of exercise, lack of prevention against childhood diseases.

In the HHS testimony presented to this subcommittee in February, we were told that the economic cost of smoking is somewhere in the neighborhood of $17-26 billion in 1979 and the economic cost of alcohol abuse exceeded $39 billion in the mid-1970s.

How will block grants effectively address these problems?

Answer: For three years, CDC has awarded grants to State health agencies designed to build capacity in State and local health departments to programs that can prevent many of today's foremost killers--e.g., heart disease, cancer, stroke, diabetes, and accidental injury--associated with risk factors such as those listed above. The purpose of these grants was to assist States in initiating, encouraging, and becoming a focal point for delivery of health education programs. The grants also encouraged participation and coordination of efforts by public and private organizations in these types of prevention programs. Thus, a core capability now exists in the States to continue such programs under the block grants.

HEALTH INCENTIVE GRANTS

Question: The Health Incentive Grant Program, also known as 314(d) of the Public Health Service Act has been a targeted for a $27 million rescission in FY '81 by the Reagan Administration. The Carter Administration first proposed this rescission as well as the elimination of this program for FY 1982. Yet the Reagan Administration, while agreeing to the rescission, has included the 314(d) program in its Preventive Health Service block grant proposal. What are your reasons for rescinding $27 million from this program in fiscal 1981?

Answer: The rescission will contribute substantially to the reduction of Federal outlays in FY 1981. Since the Health Incentive Grant constitutes a relatively small part of the approximately $3 billion expanded annually by States and localities for public health services, the impact of this rescission will be minimal. In lieu of proposed funding for this program in 1982, the administration has proposed a consolidated prevention health block grant. Under this proposal, States will continue to have the flexibility to fund programs such as those covered under health incentive grants if such programs are considered a high state priority.

Question: Will funds for this program be included in the block grant proposal?

Answer: Yes, under the block grant, each State will receive their pro rata share of funds based upon the FY 1981 appropriations for the categorical programs included in the block grant in FY 1982.

Question: If so, isn't this unnecessary since the entire preventive health block grant is designed to become a type of health incentive program at the States' discretion?

Answer: The proposed level and allocation of funds to States was developed based on the need to facilitate an orderly and adequately funded transition to the block grant. While the objectives of the block grant and 314(d) grants are similar, the block grant would not require States to compile extensive plans as the amended Section 314(d) would require at a similar funding level.

CHRONIC DISEASES

Question: You are proposing to rescind $494,000 of FY 1981 funds for chronic diseases. What will be the effect of this rescission on studies relating to arthritis?

Answer: These studies will be terminated.

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

Question: In your view, how serious are the problems of disease and injury related to the work place?

Answer: Injury, death and disease resulting from occupational hazards is one of the Nation's most serious, preventable public health problems. There are about 100 million workers in 5 million workplaces across the country. According to the Department of Labor's Bureau of Labor Statistics, about 1 out of every 11 workers in private industry suffers an occupational injury annually; about 3 out of 100 workers are disabled from these injuries. And approximately 1 worker in 12,000 is killed on the job each year. Occupationally related disease is a more pervasive and elusive matter. Lack of awareness that many diseases are work related, long latency periods and confounding factors like environmental exposures make it extremely difficult to derive reliable estimates of occupational disease incidence.

Question: What percent of cancers are attributable to exposure within the workplace?

Answer: The Council for Environmental Quality estimates that 20 percent of all cancers may be related to agents in the workplace. This estimate, however, recognizes that many factors interact to cause cancer. It should be noted that estimates such as these tend to be controversial, with varying opinions as to the impact of occupational as well as other factors in the etiology of cancer. NIOSH believes the 20 percent figure to be a reasonable estimate, because it recognizes the multiplier effect of interacting cancer-causing agents which the oft-quoted 1 to 5 percent estimate ignores. NIOSH recognizes that additional research and analysis are necessary to place such an estimate on firmer scientific ground.

ENVIRONMENTAL HEALTH

Question: Do you expect the focus of CDC to change in the next 10 years from infectious disease control to environmental disease control?

Answer: Instead of a change in the focus of CDC away from infectious disease control to environmental health, I expect to see the maturation of environmental health from its present largely nascent state to a major mission of CDC. The result will be a CDC that provides national leadership for a comprehensive effort to prevent death and disease from both infectious and environmental threats.

There is little indication that the infectious diseases will disappear as a public health problem in the years ahead; whereas great progress has been made in the control of many of the "old line" infectious diseases (diphtheria, tetanus, typhoid fever, measles, mumps, and rubella), maintenance of that control will require continued application of the best available disease control expertise and technology. Moreover, control of newly recognized infectious disease problems (as exemplified by Legionnaires' disease and the Toxic Shock Syndrome) will require sustained scientific and technologic leadership. On the other hand, CDC's expertise in epidemiology, laboratory science, and prevention methodology will be increasingly called upon to address environmental health problems as knowledge of hazards increases.

The relationship between toxic hazards (especially toxic wastes) and health has not been clearly defined. CDC will be increasingly called upon to assist in providing this definition. Moreover, CDC is expected to be involved in providing more accurate view of the nature of overall environmental risks to which Americans are exposed. In this regard, accidents and violence also are profound environmental hazards for Americans for the first 5 decades of life.

Question: As CDC broadens the scope of its responsibility in environmental health problems, the use of toxicological testing facilities and equipment will expand. Are current resources sufficient to respond to requests for toxicological assistance in emergencies?

Answer: As CDC services and responses to States and local agencies expand, the requests will continually grow. There will never be sufficient resources to respond to all requests. The most difficult task is disengagement from an investigation and turning over the health problem to local units. This requires a buildup of State and local resources for dealing with more problems locally.

URBAN RAT CONTROL PROGRAM

Question: The Urban Rat Control Program is one proposed by the Department for consolidation into the Preventive Health Block Grant. To what extent would technical assistance continue to be provided by the Department?

Answer: Since the inception of the program in 1969, managerial and technical assistance has been provided to 9 States, the District of Columbia, and 102 individual communities. This has resulted in the transfer of technology necessary to continue components of a comprehensive urban rat control program.

ENVIRONMENTAL HAZARDS

Question: In February testimony submitted to this subcommittee, Department witnesses testified that only in certain limited events is it necessary to conduct physical examination of people living in areas affected by environmental hazards. It appears that they believe, rather, that it would be sufficient to review and confirm health status with private physicians, or to collect samples of blood and/or urine for laboratory analysis. Do you agree with this?

Answer: Yes, we do agree. Often, however, it is necessary to review and confirm the health status of citizens with their private physicians or to collect samples of blood and/or urine for laboratory analysis. CDC has the ability to carry out these kinds of activities.

Question: Do you have adequate personnel to conduct health status checks? Thorough physical examinations?

Answer: Our current staff of physicians and other medical personnel is not large enough to provide the examinations without severe disruption of other critical CDC functions in the areas of epidemiology and laboratory services. We would, however, look within the PHS, to private medical institutions, and to State health agencies for support in this area.

Question: Do you plan to establish a registry of public health incidents where health problems have been reported?

Answer: The question of registries is complex, both from a scientific standpoint as well as logistically and financially. PHS has set up a committee with representatives from NIH, FDA, CDC, the Office of the Assistant Secretary for Health, and from the Internal Revenue Service to examine the issues and make recommendations to the Assistant Secretary. Their report is due May 1, 1981. In the interim, registries are already in place for a number of incidents such as the Love Canal episode, the PBB spill in Michigan, DDT and PCB in Triana, Alabama, and the TMI and Smokey radiation incidents.

SEX EDUCATION

Question: In February's hearings, the Department was asked about sex education activities within CDC and told our subcommittee, "The Department of Health and Human Services is not directly involved in the delivery of sex education programs..." except indirectly in family planning activities. Yet the administration is proposing a $1.97 million rescission for risk reduction/health education and the narrative accompanying the rescissions States, "under the proposed rescission, planned activities related to sex education would be cancelled." Please explain the discrepancy between the Department's earlier response and your justification for this rescission.

Answer: CDC has carried out sex education research, but has never been involved in financing direct delivery of sex education. These research studies have focused on identifying successful programs for use by parents and by schools in communities that have chosen to present sex education programs and on documenting the factors that make them successful. The rescission cancels this sex education research support at CDC; there is no program to support delivery of sex education programs.

Question: Within the health education/risk reduction portion of the block grant proposal, do you plan to allow federal funds to be used for sex education activities if States so choose?

Answer: The health education/risk reduction grants have been used to address a number of preventable risk factors. However, to date, no State has proposed to conduct sex education programs. Under the block grant concept, there would be no restrictions on States to prohibit the use of grant funds for sex education.

HEALTH EDUCATION

Question: The subcommittee has heard from various State Health Education programs that funds are not getting to the schools from the local health departments. Since the Department of Education has access to local school systems through State education departments, wouldn't it be more effective to have the Department of Education administer this program?

Answer: Health education directed at the needs of children takes many channels, of which schools are one. Others include parents, peers, community organizations, media, and health care programs. It is important that health education messages in all of these channels be consistent and complementary, that they be based on sound preventive medicine practices and reflect current biomedical research, and that they be linked to preventive health services that families may elect to use in response to health educaton. For these reasons, it is appropriate for health agencies to be involved in school health education. As noted earlier, CDC has worked closely with the Department of Education carrying out this aspect of our comprehensive health education program.

Question: The fiscal 1982 budget narrative makes mention of a national patient education workshop project as one of the accomplishments of the Bureau of Health Education. The American Hospital Association is paid to be be involved in this project. Why should the Federal government continue to fund this project?

Answer: This project involved a planned series of activities designed to develop and disseminate to hospitals improved methods of patient education that can be used in patient and in ambulatory settings. Funds already obligated in FY 1981 will support completion of the current phase of this project. No further federal funding for this type of activity is anticipated in FY 1982.

LABORATORY ERRORS

Question: In last year's testimony CDC stated that an important method for reducing health care costs associated with laboratory services is reducing clinical laboratory error rates. What does CDC plan to do alone or with other public or private agencies to reduce the occurrence and cost of clinical laboratory errors?

Answer: CDC is undertaking studies designed to (1) develop a model output-oriented performance evaluation system for use by States that will determine the extent and cause of laboratory errors with patient specimens, and (2) develop a model laboratory assistance system for use by States so laboratories with a problem can obtain help in quickly solving their problem. This system will build on the CDC's existing effective program of technical training and consultation to States and private organizations for transferring the methodology for proven diagnostic procedures and correcting recognized deficiencies in laboratory personnel. These two systems, once developed, field tested and shown to be sensitive and cost effective, will be offered as a substitute for the current laboratory evaluation systems that depend heavily upon personnel qualifications and strict standards for internal quality control processes.

CONSULTANTS

Question: The Fiscal 1982 Carter Administration budget requested a 10 percent increase in consultant services for CDC. Based on your review, what is your budget proposal in this area, particularly in the areas of epidemic services and technology?

Answer: The Reagan Budget reflects a decrease from the previous year of 13.8 percent for all consultant services. In 1982, the budget for Epidemic Services is $187,000 and $90,000 for Technology Development and Application.

TUBERCULOSIS

Question: How serious a problem is tuberculosis today?

Answer: Provisional data indicate that a total of 27,983 cases of tuberculosis were reported to the Centers for Disease Control in 1980.

Tuberculosis is a communicable bacterial disease, usually affecting the lungs, resulting in transmission of bacteria through the air to other persons. Once an individual has become infected, the bacteria may remain alive in the body in a dormant state for years. Unless preventive treatment is given for the dormant infection, about 10 percent of these infected individuals will eventually develop tuberculosis and become spreaders of the disease. There are an estimated 10 million infected individuals in the United States.

Although tuberculosis has been slowly declining for years, there are indications that the direction of the trend in the number of tuberculosis cases may be changing toward an increase. From 1953 through 1978, the average annual decrease was about 5 percent. However, in 1979 the decrease was only 3 percent, and provisional data for 1980 show a 0.6 percent increase. The number of cases reported through the sixth week of 1981 is about 2 percent above the number reported in the same period of 1980.

Tuberculosis in children, an indicator of ongoing transmission in the community, has also shown a trend reversal. In 1979, there were 989 cases of tuberculosis in children 0-4 years of age, an increase of 18.3 percent over 1978.

Control has been complicated by the ability of bacteria to develop resistance to antituberculosis drugs when treatment is not properly taken. Community outbreaks of drug-resistant tuberculosis have occurred, and presently about 7 percent of newly diagnosed cases have disease caused by drug-resistant bacteria, indicating that these difficult-to-treat organisms are being transmitted.

All of these factors are contributing to the persistence of tuberculosis as a serious community health problem, despite the availability of effective diagnostic and curative services for individual patients.

Question: What is the budget request for programs for TB control?

Answer: The budget request for FY 1982 is $3.252 million.

VENEREAL DISEASE

Question: Will you continue National VD Hotline?

Answer: During fiscal year 1981, the National VD Hotline will be supported by grant funds awarded under Section 318(b) of the Public Health Service Act. This categorical authority, which expires this year, provides that at least 5 percent of the funds appropriated for venereal disease project grants must be expended for the conduct of research, demonstrations, and public information and education. The Administration's Preventive Health Service Block Grant proposal contains no such provision. Therefore, activities such as the National VD Hotline will terminate unless support from some other source can be identified by the end of the current funding period.

ALLOWANCE PER TRAINEE

Question: I note that the institutional allowance for individual predoctoral trainees is at $4,000 per trainee and that this is $1,000 higher than the allowance for institutional predoctoral trainees. Please explain the difference in this allowance.

Answer: Under institutional training awards, education costs (tuition and fees) are included as a separate item in addition to stipends and institutional allowances. However, in the case of individual predoctoral fellowships, there is no provision for tuition and fees as a separate expense. Therefore, the institutional allowance has been authorized at a higher level to include these costs.

CLINICAL INVESTIGATORS

Question: Last year, we noted that a critical problem existed with regard to the supply of clinical investigators in the United States. Could mechanisms be introduced into this year's training budget to help rectify any shortage? At what costs?

Answer: In response to the Subcommittee's request last year, the NIH has prepared a report, Assuring the Supply of Clinical Investigators, which addresses this subject in detail. The report is being submitted to the Committee.

As mentioned in the report, the NIH does have in place, or under development, several programs that are specifically designed to encourage career development in clinical investigation. Included in this category are the following: the Short-Term Training Program for Students in Health Professional Schools, which has been in operation for about a year, is designed to offer a 3-month experience to students in order to expose them to the advantages of a research career; the Medical Scientist Training Program, considered one of the most effective means of developing and retaining clinical investigators, currently supports over 650 students who will earn the combined MD/PhD degree; the Clinical Associates Program, which has considerable expansion potential, provides both the training environment and research development support for physicians with clinical specialty qualifications; and the Program on Special Training for Clinical Investigation, now under development at the NIH, is being designed to provide research training for those already trained to deliver patient care.

Additional funds could be effectively utilized to expand existing programs and to initiate new programs.

TRAVEL COSTS

Question: What policies does NIH follow in controlling travel expenses by the recipients of research grants and contracts?

Answer: For grants, proposed travel is first assessed as part of the peer review process and is recommended for approval as requested, is deleted, or is adjusted. In the post-award setting, reduction in a major cardiovascular initiative, the Atherosclerosis SCOR program, which has been successful in providing basic and clinical advances over the past decade; and the diminution of four pulmonary programs that have contributed to our increased understanding of major lung diseases.

Reductions will also be made in all contract programs including commitments to certain clinical trials, particularly the MILIS (Multicenter Investigation of Limitation of Infarct Size).

National Institute of Dental Research

As a result of the 1981 rescission the NIDR intramural programs will terminate the taste research activities and will delay procurement of certain needed research instrumentation. The rescission will also prevent the award of approximately six new research project grants. These projects span several areas such as: studies of the mechanisms of bone resorption; investigations of oral bacterial adherance mechanisms; identification and classification of microorganisms associated with peridontal disease; studies of wound healing with reference to acquired oralfacial defects; and studies of corrosion and toxicity of restorative materials.

National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases

The proposed rescission for this Institute will impact primarily in the areas of research grants and the diabetes centers. Except for the latter, all the reductions are spread throughout the Institute's program categories: arthritis and related diseases, musculoskeletal diseases, skin diseases, diabetes, endocrinology and endocrine disorders, metabolic diseases, digestive diseases, nutrition, kidney disease and urology, hematology, and intramural research. When distributed across all programs, the impact should not be substantial.

National Institute of Neurological, and Communicative Disorders and Stroke

Priority will be given by the NINCDS to support of research project grants, with only slightly fewer new awards being made.

The reduction in research and development contracts will eliminate a study of the endocrinological parameters (hormone production) in experimental anticonvulsant drugs. Also a new stroke clinical research program will not be initiated. Work under this contract would determine the availability and efficacy of advanced care and treatment of stroke patients through controlled clinical trials and relevant clinical research. A clinical trial on the pharmacologic prevention of post-traumatic epilepsy will be reduced to one-third of the requirements or not funded at all.

The reduction in the Intramural Research Program will delay the full implementation of the Positron Emission Tomography (PETT) Program including purchase of peripheral equipment. Development of the communicative disorders clinical research branch will be delayed. Further development of brain tumor research will be delayed, including development of brain tumor models and the evaluation of long-term effects of brain tumors and rehabilitation of patients.

National Institute of Allergy and Infectious Diseases

Competing research project grants awarded by NIAID will be reduced slightly, mostly in the area of infectious diseases. The net effect is to reduce research on technologies and advances in obtaining solutions to such problems as herpes genitalis, gonorrhea, or bacterial and viral infections of the lung or brain.

National Institute of General Medical Sciences

Because of a number of dramatic breakthroughs that have occurred in the past few years, the field of genetics research is currently the most exciting area within the scope of the NIGMS. By the use of modern molecular genetics, scientists are now able to analyze human cells in a manner not heretofore possible; we are, as a result, moving more rapidly toward an understanding of cancer, autoimmune disorders, thalassemia, and the formation of abnormal hemaglobins. The proposed reduction in the NIGMS research budget for 1981 will necessarily have some impact on the rate of progress we continue to make in this area. However, we will continue to fund the very best applications within available funds.

A similar situation exists within the Institute's Cellular and Molecular Basis of Disease Program. Here again, rapid advances have been made in the past few years. Our knowledge of how the cell membrane is structured and how it functions, for example, promises to open up a number of areas for fruitful investigation. Embedded in the membrane are various types of receptor molecules, which interact with specific molecules from distant parts of the whole organism; these receptors are known to be involved in a wide range of biochemical processes, including everything from the secretion of hormones to the body's reaction to various drugs. Studies regarding such receptors are also of great importance to an understanding of the mechanisms involved in such disorders as diabetes, atherosclerosis, and cancer. There will be a modest reduction in the number of research grants supported in this area.

National Institute of Child Health and Human Development

The NICHD supports a wide range of research activities in the areas of Population and in Research for Mothers and Children. Research in both areas will be affected by the rescission. Reductions will be made in research project grants, research centers, research and development contracts, and intramural research. Promising areas of research that are susceptible to impact include the treatment of high risk pregnancies and high risk infants, prevention of premature labor, identification of children with learning disabilities, clinical applications of human growth hormone (hGH), and contraceptive development and contraceptive evaluation studies.

National Eye Institute

Examples of NEI grant-supported research that may be affected include: studies to develop better treatments for tear abnormalities, a leading cause of visual impairment and chronic discomfort among the elderly; tissue culture studies to better understand the normal and cataractous lens; proposals to develop means of preventing and treating glaucoma secondary to ocular injury; and projects to improve the techniques used to study the development and functioning of the visual nervous system components.

Ongoing contracts to determine the effectiveness of early treatment of diabetic retinopathy will be funded at a reduced level. As a result, fewer clinics may have to be supported and the rate at which patients could be recruited into the study will be slowed. This may have the effect of extending the amount of time needed to gather and analyze data and may delay the communication of research to clinicians.

National Institute of Environmental Health Sciences

The rescission will reduce research funds available to NIEHS for the research centers program, research and development contracts, and intramural research. At the environmental health science centers, rising costs and stable level of support will force some centers to delay or eliminate research projects in pharmacology, toxicology, and human epidemiology. New targeted research and test development projects important to the objectives of improving the efficacy and speed of chemical toxicology tests will be deferred. The equipping of research laboratories and supporting services at the new NIEHS facilities will be deferred. This will result in delaying research in fields such as molecular genetics, comparative pathology and physiology, which holds promise of improving the nation's capability to identify and control environmental factors that influence human health.

National Institute on Aging

For the NIA, the rescission will slightly delay research progress in such areas as neurosciences, immunology, and nutrition because of the reduction in research project grants. Every effort will be made, however, to maintain a balanced program. Further inclusion of women in the Baltimore Longitudinal Study of Aging will be delayed, making it more difficult to obtain the necessary cohort of study subjects for comparison of age differences in men and women.

Division of Research Resources

The rescission will enable the Division to maintain the most vital portions of its five extramural programs; however, all programs will share in the rescission and operate at a reduced level in 1981. At the rescission level 71 General Clinical Research Centers will be funded -- 4 less than under the continuing resolution; 41 Biotechnology Resource grants will be funded -- 7 less than under the continuing resolution; 2 Biotechnology Research grants will be funded -- 3 less than under the continuing resolution; 45 Laboratory Animal Sciences grants will be funded -- 3 less than under the continuing resolution; 74 Minority Biomedical Support grants will be funded -- 10 less than under the continuing resolution; and 13 research and development contracts will be funded -- 7 less than under the continuing resolution. Also, there will be a reduction in the funds available under the Biomedical Research Support program formula for distribution to eligible institutions.

This proposed rescission will delay some research, since biomedical researchers who would have used the resources not available under the rescission may have to delay their work, unless they can find other support in suitable research environments.

Office of the Director

The proposed rescission for the Office of the Director will impact on the administrative structure supporting research, primarily as a result of reduced funds for personnel services and general operation.

LIST OF RESEARCH CUTS

Question: For each NIH Institute where there is a 1981 rescission, please provide comprehensive information on how the proposed cut will impact on specific research efforts. For example, how will specific Cancer, Heart or Diabetes research projects be affected by any cutback in new or continuing research grants, contracts, intramural research, etc. To what extent will research results be delayed by your proposed rescissions? Be specific.

Answer: A major portion of the rescission amount is in the area of research training, which is supported by all the Institutes. Slightly fewer trainees will be supported in FY 1981 than in FY 1980; however, the major emphasis of the rescission is contained in the proposal to eliminate institutional allowances and indirect costs. It is unknown at this time what impact these reductions may have on the ability of institutions to support trainees in biomedical research. All trainees will continue to receive awards for their tuition, fees, and stipends.

With regard to specific research efforts, the impact of the proposed rescission on each NIH Institute is described in the following paragraphs.

National Cancer Institute

Reductions will be taken in the following NCI research activities: biological and chemical carcinogenesis, nutrition, immunology, tumor biology, preclinical and clinical treatment, and diagnostic research. These activities are supported through research grants and contracts and within the NCI's intramural research program.

When making reductions in FY 1981, NCI tried to maintain a balance between research grants, contracts, intramural research, and training so that essential research would not be impaired or delayed.

National Heart, Lung, and Blood Institute

In the area of research project grants, Requests for Applications for the competitive continuation of a targeted program in sudden cardiac death and basic studies of cardiomyopathies and pulmonary endothelial research will be reduced. The delay will curtail somewhat the advance of new research ideas and new fundamental knowledge, postpone the acquisition of results, and delay implementation of strategies to solve specific disease problems.

The Institute will negotiate downwards the commitments of all 59 of its research center grants by approximately 5%. Thus, all ongoing center programs will be continued, but at a reduced level of support. The reductions will result in a decreased level of activity in such areas as the Sickle Cell Centers, which have provided valuable research, training, and counselling to the black community, and in Specialized Centers of Research (SCOR) focused on major health problems in the heart, lung, and blood areas. This will result in a

RESEARCH COST SHARING

Question: You are proposing to delete Section 204 of the General Provisions. This section prohibits research grants to any institution that does not share in paying for the cost of the research. How much cost sharing has there been under research programs administered by the Department?

Answer: We cannot tell you in terms of actual dollars, but the vast majority of institutional as well as project-by-project cost sharing agreements submitted by grantees propose to contribute 1 to 10 percent of the total project costs. In fact, the actual percentage of cost sharing exceeds the proposed level in most cases.

Question: Do you expect any decrease in the amount of cost sharing if Section 204 is eliminated, and if so, how much?

Answer: We anticipate no change in the degree of cost sharing, only in the requirement to formally propose and document cost sharing.

Question: How can we be sure that the amount of cost-sharing will not fall below your expectations if Section 204 is eliminated?

Answer: There are no guarantees, but cost sharing requirements allow an institution to propose "token" contributions now.

CONSOLIDATION OF HEALTH RESEARCH APPROPRIATIONS

Question: Appropriations for biomedical research are contained in 16 separate accounts. While such a system enables Congress to influence priorities, it also leads to the possibility that resources will be allocated on the basis of political factors rather than scientific merit. Separate appropriations also make it more difficult to shift funds quickly to meet the most promising new research opportunities. What improvements in research management do you foresee if all NIH appropriations were consolidated into a single account?

Answer: The consolidation of all NIH appropriations into a single account would facilitate the shifting of resources to meet new research opportunities. However, I do not believe that a consolidated appropriation would significantly alter NIH research management. The complexity of the NIH mission and the level of funding require that considerable administrative evaluation and oversight be carried out at or within the individual Institutes. The basic administrative structure now in operation would still be utilized regardless of a consolidation of the appropriations accounts.

Question: Would additional legal authority be necessary to fund all of the NIH activities out of a single appropriations account?

Answer: There is no additional legal authority necessary to fund all the NIH activities out of a single appropriation account. an increase in the authorized domestic travel level by way of rebudgeting is subject to local review by the Institutional Prior Approval System. Any proposed foreign travel requires prior approval for the NIH awarding unit.

NIH Manual Issuance 6000-3-15.309-44 states the NIH policy on "Travel of R&D Contractor Personnel." This policy requires that all domestic and foreign travel proposed by contractors must receive the prior review and approval of the NIH. Specific amounts for each category are set forth in the contract and require the Government's approval for expenditures in excess of the specified amounts. (Note: OMB Circular A-21 allows educational institutions to exceed the amount allotted in the contract for domestic travel by "25% or $500 whichever is greater.")

HEALTH PRIORITIES

Question: The revised budget request for the National Institutes of Health for fiscal year 1982 is about 10 percent more than the amount provided in fiscal year 1980. At the same time, all other programs in the Public Health Services decline by about 22 percent from the 1980 base. Since most discretionary programs have had to be cut back, do you think a 10 percent increase in the NIH budget is consistent with Government-wide budget priorities, especially in the face of a 22 percent cutback in all other health programs within the Public Health Service?

Answer: The NIH budget could be viewed as inconsistent if the Administration's purpose were to restrain all Government spending equally. But the President's guidelines, as set forth in his "Program for Economic Recovery," focus budget-cutting efforts on particular kinds of spending. The Administration seeks "to restrain Federal involvement in areas that are properly left to State and local governments or to the private sector." Concurrently, it aims "to shift Federal budget priorities so that Federal resources are spent for purposes that are truly the responsibility of the Federal Government." These two guidelines, in particular, help point out the appropriateness of the FY 1982 NIH budget as compared to PHS agencies overall.

The Administration's support for NIH stems from its recognition of basic biomedical research as a true responsibility of the Federal Government. The risk and expense involved in basic research have prevented the private sector and the States from making a substantial investment in this area. The universities, where most basic health research is performed, receive only 3 percent of their support for this purpose from industry and nearly 80 percent from NIH. Today, an estimated 80 to 90 percent of the support for undifferentiated, fundamental, or basic research is underwritten by the Federal Government.

Question: How do you account for the fact that with all the money we have spent on biomedical research, the United States still ranks well below other countries in life expectancy?

Answer: Several Western European countries and Japan report better life expectancy and infant mortality rates than the United States. All the countries that exceed the United States in these statistics are small and are racially and ethnically homogeneous; most have some form of universal health insurance making medical care available to all regardless of socioeconomic status. In none of these features is the United States comparable. The vast complexity of this country in terms of race, ethnic groups, social and economic status, education, urbanization, and sheer size and geography produces problems that cannot be addressed, much less overcome, by biomedical research. The morbidity and mortality statistics of the United States compared with other highly complex societies is very favorable.

Consideration must also be given to the role of life style in morbidity and mortality statistics. Despite known relationships between smoking and health, and between dietary excesses and health, Americans persist in self-indulgence that is later reflected in poorer health statistics. To these factors can be added failures of individuals to follow therapeutic advice, thus subverting the benefits of scientific achievement that are offered to them.

It should be noted that infant mortality in the United States is declining at a very fast pace. Between 1965 and 1979, infant mortality declined by 47 percent. Although the decline in infant mortality has been observed in all states, there are wide variations in magnitude from state to state that illustrate the complexity of our society.

SAVING INSTITUTIONAL ALLOWANCES

Question: If the subcommittee decided to disagree with your request on institutional allowances and indirect costs, how much would we then be able to rescind in fiscal 1981?

Answer: The total amount proposed for rescission for NIH is $126 million. Of that amount, $41 million is for institutional allowances and $9.2 million is for indirect costs for research training. Therefore, if the request on these two items were denied, the remaining rescission amount would be $75.8 million.

TRAINING

Question: The one danger in your plan to deprive colleges of special training allowances is the negative impact this could have on maintaining the Nation's supply of talented researchers. In short, you could discourage people from entering the field. What steps are you taking to make it clear this is not your intention?

Answer: Every effort is being made to assure talented people seeking research careers that funds will be available to provide stipends, tuition, and fees for those with high qualifications for a research career. Furthermore, there has been widespread discussion and acknowledgment of the attempt to stablize funding opportunities for new and competing research grants to guarantee support for the future research efforts of well-qualified investigators. Thus, it is hoped that individuals will seek research training knowing that there will be reasonable assurance of their receiving support to carry out the research they have been trained to do.

Question: To what extent will you encourage foundations and other private groups to help provide sufficient funds for research training in the United States?

Answer: We are attempting to stimulate non-Federal support for research training. Indeed, discussions have been held with members of the Hartford Foundation, the Searle Foundation, and members of the Pharmaceutical Manufacturers Association on this subject. Some support is now available and may increase in the future.

LEGAL REQUIREMENTS FOR INDIRECT COSTS

Question: Is there a legal requirement to provide indirect costs on research training and awards?

Answer: The current regulations for National Research Service Awards do not specifically speak to indirect cost for these awards one way or the other. The subject of costs is addressed more generally in the regulations as follows: "The amount of any grant award shall be determined by the Secretary on the basis of his estimate of the sum necessary during the budget period: (1) To provide stipends and allowances to individual recipients of awards and payments to the institution . . . and (2) otherwise to carry out the grant award."

Question: If there is no legal requirement on indirect costs, what is the basis for your having paid them in the past?

Answer: These costs have been paid partly because of tradition and partly through a sense of equity. As far back as 1946, the National Advisory Health Council agreed to an 8 percent indirect cost policy to be effective January 1, 1947. Through the years, that original rate was raised several times for research grants, but the 8 percent rate for training has been retained. Our sense of equity relates to the fact that there are real overhead costs such as operation and maintenance of facilities, depreciation, and administrative salaries associated with sponsoring a training program.

TRAINING

Question: You have proposed to cut institutional allowances and indirect costs in FY 1981. Some of the schools that will be affected are the largest in the country, such as the University of Washington, Harvard University and Yale University. Why can't they pick up these costs themselves?

Answer: The Administration believes that academic institutions can indeed pick up the current amounts now provided by the Government through institutional allowances and indirect costs. It is appropriate that non-Federal groups share the burden of fiscal austerity.

Question: In FY 81 you plan to reduce institutional allowances and indirect costs related to research training. Of the $50 million that appears to be involved, what portion has already been awarded and can no longer be regained by the Federal Government?

Answer: As of March 31, 1981, approximately $6.5 million had been obligated by the NIH for institutional allowances and indirect costs. Discussions are underway at this time to determine how much of these funds can be regained.

Question: If your proposal for cutting back on special training allowances goes through, you may have to ask some schools to return money they already have received. Which Institutes will be required to actually take back money from colleges and universities?

Answer: Each of the 11 research Institutes of NIH had made some awards prior to the proposed changes under which institutional allowances and indirect costs had been paid. Therefore, every Institute will be affected.

Question: Please provide for the record a listing of schools which must reimburse the Government.

Answer: The following is a list of the institutions that have received NIH training grants under the NRSA as of March 31, 1981. No determination has been made regarding repayment.

University of Alabama, Birmingham
Talladega College, Alabama
NIADDK Epidemiology Field Studies, Arizona
University of Arizona, Tuscon
University of California, Berkeley
University of California, Davis
University of California, Irvine
La Jolla Cancer Research Foundation
Salk Institute for Biological Studies
Scripps Clinic and Research Foundation
University of California, San Diego
Estelle Doheny Eye Foundation
University of California, Los Angeles
University of Southern California
California Institute of Technology
University of California, San Francisco
University of California, Santa Barbara
University of California, Santa Cruz
Stanford University
Los Angeles County Harbor - UCLA Medical Center
University of Colorado, Boulder
University of Colorado Health Sciences Center
Colorado State University
University of Connecticut Health Center
Yale University
University of Connecticut, Storrs

George Washington University
Georgetown University
University of the District of Columbia
University of Florida
University of Miami
Emory University
Northwestern University, Chicago
University of Chicago
University of Illinois Medical Center
Northwestern University, Evanston
University of Illinois, Urbana-Champaign
Indiana University, Bloomington
Indiana University-Purdue University at Indianapolis
Purdue University, West Lafayette
University of Iowa
Tulane University of Louisiana
Jackson Laboratory, Maine
Mount Desert Island Biological Laboratory
Johns Hopkins University
U.S. Armed Forces Radiobiology Research Institute
National Institutes of Health
University of Maryland, College Park
Frederick Cancer Research Center
Beth Israel Hospital
Boston University
Children's Hospital Medical Center, Boston
Harvard University, Boston
Massachusetts General Hospital
New England Medical Center Hospital
Peter Bent Brigham Hospital
Sidney Farber Cancer Institute
St. Elizabeth's Hospital of Boston
Harvard University, Cambridge
Massachusetts Institute of Technology
Worchester Foundation for Experimental Biology
Brandeis University
Marine Biological Laboratory, Woods Hole
University of Massachusetts Medical School
University of Michigan, Ann Arbor
Michigan State University
University of Minnesota, Minneapolis-St. Paul
Mayo Foundation
University of Mississippi Medical Center
University of Mississippi
University of Missouri, Columbia
St. Louis University
Washington University
University of Nebraska Medical School
Princeton University
University of New Mexico, Albuquerque
Albana Medical College
State University of New York, Buffalo
Cold Spring Harbor Laboratory
Cornell University, Ithaca
Columbia University
Cornell University Medical Center
Downstate Medical Center

Hunter College
Mount Sinai School of Medicine
New York University
Rockefeller University
Yeshiva University
Eastman Dental Center
University of Rochester
State University of New York, Stony Brook
University of North Carolina, Chapel Hill
Duke University
NIEHS Environmental Health Sciences Center
Children's Hospital Medical Center, Cincinnati
Case Western Reserve University
Ohio State University
Medical College of Ohio, Toledo
University of Oklahoma Health Sciences Center
Oregon State University
University of Oregon
Good Samaritan Hospital and Medical Center
Medical Research Foundation of Oregon
University of Oregon Health Sciences Center
Pennsylvania State University Hershey Medical Center
Drexel University
Institute for Cancer Research, Philadelphia
Temple University
University of Pennsylvania
University of Pittsburgh
Pennsylvania State University
Brown University
Medical University of South Carolina
South Carolina State College
University of Tennessee
St. Jude Children's Research Hospital
Fisk University
Tennessee State University
Vanderbilt University
Oak Ridge National Laboratory
University of Texas
Texas Agricultural and Mechanical University
University of Texas Health Science Center, Dallas
North Texas State University
Tarrant County Hospital District, Texas
University of Texas Medicine Branch, Galveston
Baylor College of Medicine
Rice University
University of Texas Health Science Center, Houston
University of Texas Health Science Center, San Antonio
University of Utah
University of Virginia, Charlottesville
Virginia State University
Virginia Commonwealth University
Washington State University
Fred Hutchinson Cancer Research Center
University of Washington
Virginia Mason Research Center
West Virginia University

University of Wisconsin, Madison
Catholic University of Puerto Rico
University of Puerto Rico Medical Sciences
McGill University
University of Toronto
University of Aarhus, Denmark
National Institute of Health and Medical Research, Paris
Pasteur Institute
University of Dusseldorf
European Molecular Biology Organization, Heidelberg
Rupert Charles University of Heidelberg
Philipps University of Marburg
Hebrew University of Jerusalem
Tel Aviv University
University of Tokyo
Netherlands Central Organization
University of Oslo
Caroline Institute, Stockholm
Rowett Research Institute, United Kingdom
Medical Research Council, Cambridge
University of Cambridge
Imperial Cancer Research Fund, London
Medical Research Council, London
University of London

RESEARCH GRANTS - INDIRECT COSTS

Question: We understand that payment for indirect costs related to research grants is supposed to average 28.6 percent of the grant. Yet, there is concern that for some universities, their share of the grant may go far higher than the standard percentage. What can you tell us about this?

Answer: The indirect cost rate varies among universities depending on the base upon which the rates were calculated, whether the institution is public or private (private institutions usually have less ability to recapture costs), and the region of the country (e.g., higher energy costs in some locations).

Question: Are there any instances where a university's share for indirect costs may go far higher -- say, 60 percent?

Answer: Among the 100 institutions that received the largest amounts of NIH extramural funds in FY 1980, the highest percentage for indirect costs was 46.8

Question: What safeguards do you have -- or do you plan to institute -- to make certain that research grants are used for research and not to help schools meet their overhead costs?

Answer: The safeguards are contained within the negotiation system itself. In each case, a recipient institution must prepare an indirect cost rate proposal and submit it to the Office of the Regional Comptroller in the HHS Region in which the institution is located. The proposal must be developed in accordance with principles and procedures appropriate to the type of institution involved (e.g., OMB Circular A-21 applies to educational institutions). An allowable indirect cost rate is then negotiated by the Regional Comptroller's office and published for use by all awarding agencies in order to provide appropriate reimbursement.

LACK OF PHYSICIAN RESEARCHERS

Question: The NIH-Medical Scientist Training Program (MSTP) represents the principal Federal effort to deal with the problem of the dwindling number of doctors engaged in biomedical research. What is the impact of the Administration's proposed research training cuts on the MSTP Program?

Answer: The decreases in the Medical Scientist Training Program in FY 1981 and FY 1982 result from the proposed elimination of NRSA institutional allowances and indirect cost payments, not from a reduction in trainees. The reaction of institutions to these reductions cannot be assessed at this time; however, it is possible that trainees will receive less academic supervision since faculty will need to devote more time to non-training activities. It is also possible that the scope of the training program will be narrowed by limited equipment and/or research facilities.

Question: We understand that the number of physicians engaged in research as a primary activity has dropped by about 50% since 1968. What can you tell us about this? (Note: Figures published by Dr. James A. Wyngaarden of Duke University indicate that the drop is from 15,441 in 1968 to 7,944 in 1975.)

Answer: The following are among the major factors cited in the trend toward decreased numbers of physicians engaged in research: greater emphasis on medical care of underserved segments of society; instability of Federal support for biomedical research and training; deletions of research-laboratory courses from medical school curricula; economic advantages of medical practice; and the deterrents associated with the current payback provisions. It should be noted, however, that while the percentage of postdoctoral fellows with a clinical degree continues to decline as compared to postdoctoral fellows with the Ph.D. degree, the absolute number of clinical postdoctoral fellows has averaged approximately 1,900 per year for the past 5 years.

TRAINING LEVELS

Question: One of the Administration's budget proposals in fiscal year 1981 is to limit the number of NIH supported trainees (or full-time equivalents) to 10,000. The figure of 10,000 is also kept constant for 1982. How much extra would it cost to support the full number of 10,567 trainees requested in the Carter Rescission budget for fiscal year 1981, assuming that only stipends and tuition were provided?

Answer: Approximately $6 million in additional funds would be required to support 10,567 trainees in FY 1981.

Question: How much extra would it cost in 1982 to support the 10,510 trainees recommended in the Carter budget?

Answer: Assuming that only stipends and tuition were provided, approximately $6.8 million in additional funds would be required to support 10,510 trainees in FY 1982.

RESEARCH PROJECT GRANTS

Question: The Administration is requesting 4,797 new research grants at NIH in fiscal 1981 and 4,899 in fiscal 1982. This is below the 5,000 level which was designed to stabilize new research grants at NIH. Don't you regard NIH research as cost-effective?

Answer: I feel very strongly that the research conducted by the NIH is cost-effective. However, with the need for reduction in Federal expenditures, it was felt that the research project grants area should participate.

IMPACT OF INFLATION

Question: It's been suggested that inflation may have reached the point where the Government should consider setting an upper limit on the share of a health research project it is willing to fund. What is your comment on this?

Answer: In the case of some of NIH's large awards, such as program projects and centers, several of the Institutes have already placed an upper limit on the amount of funds that may be requested and awarded. Other Institutes are known to have such limitation under serious consideration. An upper dollar cap for the investigator-initiated individual research project grant is not believed desirable; nor does NIH plan to limit contracts, which appropriately should cover the negotiated full-cost of the proposed procurement. On the other hand, the alterations and renovations cost category is an example of an allowable cost within a grant on which an upper limit has been in place for several years.

PROGRESS IN RESEARCH

Question: I know you are well aware of the enormous strides we are making in the field of biomedical research. To what extent will your proposed cutback in new research grants impede this progress?

Answer: I do not feel that the proposed reductions will impede the progress of biomedical research. The peer review process ensures that the most promising research will continue to be funded.

Question: What steps are you taking to make certain that the reduced number of new and competing grants does not impair our research effort?

Answer: The NIH will be able to fund approximately 4,800 competing research project grants in 1981, the same as 1980. Therefore, the research effort will not be impaired.

FOGARTY CENTER

Question: Mr. Secretary, all departments and agencies of the Federal Government are being forced to cut back programs and staff in the interests of reducing government spending.

Yet, it appears that you have not requested any rescission for the Fogarty International Center at NIH in fiscal 1981. Indeed it is the only component at NIH not to be hit with a rescission. For the time remaining in the current fiscal year, please tell us how much you can rescind from Fogarty and what the effect will be?

Answer: At the time of the development of the rescission proposals we looked very carefully at the programs of the Fogarty International Center (FIC) and determined not to propose any rescission.

The FIC did not participate in the overall NIH rescission because its budget increase from FY 1980 to FY 1981 was only 3 percent as compared to 5 percent for the aggregate NIH under the 1981 Continuing Resolution, with the majority going for administrative mandatory increases.

We would not propose a rescission at this time for FIC -- first, because of its previous low growth rate as mentioned above, and second, because of the serious impact such a proposal would have on FIC programs. For example, the International Research and Senior International Awards Programs, which are normally awarded in the third quarter of the fiscal year, remain to be funded in FY 1981. Under a rescission, these programs would take a disproportionate share of any reductions since over 25 percent of total FIC funds have already been obligated. With only 6 months remaining in this fiscal year, the flexibility of adjusting the FY 1981 budget is limited, and any reductions would cause severe disruption to overall program balance with FIC.

Furthermore, for many years the United States was more active than any other country in biomedical research. This situation is no longer true, and we must be careful not to lose the edge that we now retain in certain new technologies. We must therefore protect our bilateral agreements and exchanges with other countries to be sure that we remain aware of scientific activities throughout the world.

OFFICE OF THE DIRECTOR

Question: Mr. Secretary, all departments and agencies of the Federal Government are being forced to cut back programs and staff in the interests of reducing government spending.

Yet, it appears that you have not requested much of a rescission -- $360,000 out of $22 million budget -- for the Office of the Director of NIH in fiscal 1981. For the time remaining in the current fiscal year, please tell us how much you still can rescind and what the effect will be. Keep in mind: We are looking for the largest rescission possible.

Answer: We have taken another careful look at the Office of the Director, NIH, for possible additional rescission. Based on this review, we do not feel that additional funds can be rescinded for the following reasons:

First, the Office of the Director provides overall direction and centralized administration to the National Institutes of Health. As such, it is a labor-intensive organization that devotes approximately 70 percent of available funds to personnel services. A fairly constant rate of spending throughout the fiscal year is typical of such organizations, and, once the fiscal year has commenced, adjustments to the overall availability of funds are difficult to effect. Flexibility in adjusting the FY 1981 budget is further limited by virtue of the fact that half the fiscal year has elapsed.

Second, the Office of the Director is currently funded under a continuing resolution of $22,549,000. The presently proposed rescission of $360,000 will result in a funding level of $22,189,000. At mid-point in the fiscal year, the Office of the Director has committed 58 percent of the continuing resolution amount and 59 percent of the reduced level. If the pay raise supplemental is disallowed, the Office of the Director will be required to absorb $1,047,000 in pay raise costs, which will represent a decrease of 11 percent to the balance for the year. Further reductions would be impossible without serious restraint on the overall administration of our extramural and intramural programs, and on the centralized personnel and financial services provided.

DISSEMINATION OF RESEARCH RESULTS

Question: NIH recently established a program which is designed to improve lines of communication from the health research community to health care providers and the public. The program is known as Consensus Development and is administered by the Office for Medical Applications of Research. How can the program be improved in order to better keep the public up to date on the latest medical technologies and innovations?

Answer: The information derived from NIH consensus development conferences is widely disseminated within 2 weeks following each meeting. This information is supplied by the Offices of Information within the individual Institutes, as well as by the Office for Medical Applications of Research (OMAR) in the Office of the Director, and reaches the scientific community and the general public through four primary media: highly recognized medical speciality and subspecialty journals; state medical societies and their journals; popular magazines and journals; and major newspapers and press services throughout the United States.

OMAR is examining alternatives to the present information dissemination process to optimize the flow of health care information to the practicing physician and the public. The current practices described above, which have proven to be successful, will be expanded.

CONSENSUS DEVELOPMENT CONFERENCE

Question: In the February testimony submitted to the Subcommittee, Department witnesses testified that NIH sponsored 8 Consensus Development Conferences in 1980 and estimates that 12 conferences would be held in 1981, a 50% increase over 1980. Each of these conferences, the Department indicated, cost between $55,000 and $60,000. How many conferences do you plan to sponsor in fiscal 1982? At what cost?

Answer: The NIH plans to hold 12 to 15 consensus development conferences in FY 1982, at a cost of about $60,000 to $65,000 per conference.

Question: To what extent do you use consultants to set up these conferences?

Answer: The NIH -- through the individual Institutes -- has responsibility for the selection of consensus topics, questions to be addressed, and panelists and speakers for each conference. When appropriate, outside consultants who are expert in the subject technology are used by NIH to lend assistance in planning consensus meetings. To date, consultants have participated in planning associated with approximately one-half the conferences; in each case, only two to three consultants have been involved.

Question: What studies have you conducted to measure the usefulness of such conferences? What have been the results of those studies?

Answer: OMAR recently awarded a contract to the University of Michigan to evaluate the consensus development process as a means of technology assessment and transfer of knowledge. In addition, evaluation questionnaires are distributed to the participants at each conference, and the results are analyzed, documented, and used for the planning and improvement of future meetings. Smaller-scale evaluations of conference components, such as representatives, effectiveness of the information dissemination, clarity and usability of the conference recommendations, are also undertaken for specified conferences. OMAR plans to initiate a study of the impact of these consensus conferences during fiscal year 1981.

DUPLICATION OF RESEARCH

Question: Many agencies such as the Veterans Administration, the Department of Defense, the National Science Foundation, the Alcohol, Drug Abuse, and Mental Health Administration, the National Center for Health Services Research, the Department of Energy and various Public Health Service agencies support health research in problem areas that border or fall within the broad purview of NIH. How much of this research is duplication?

Answer: Differences in missions require different types of research emphases to serve the needs of those missions. This plurality of health research support, provided by the various agencies in support of their generic missions, is desirable and, in the view of the NIH, does not lead to wasteful duplication of effort.

Question: What coordination is there between NIH and other health research agencies to minimize duplication?

Answer: One safeguard against unreproductive duplication is provided by the very nature of the process of scientific inquiry. The vast majority of NIH support of biomedical research is provided through the funding of investigator-initiated research project grants. Each grant proposal represents an individual investigator's own ideas, special skills, training, and perspectives. Consequently, each project represents a novel approach to the research questions that are posed. It is extremely unlikely that actual "duplication" of projects would occur with any significant degree of frequency -- even within specific areas of inquiry.

The possibility of unnecessary duplication of research efforts is minimized by numerous mechanisms, including a central registry of all research projects maintained by the Smithsonian Science Information Exchange. Also, at the administrative level, there are in place a variety of mechanisms, such as interagency agreements, which define the specific responsibilities of those agencies that share a common mission boundary. In addition, to further guard against the possibility of undesirable program overlap, and to aid in identifying opportunities for fruitful collaboration, the NIH solicits the active participation of other agencies in the work of task forces and coordinating committees to plan programs and provide oversight in specific areas of research. Finally, needless duplication is avoided by continuing informal interchange among Federal program managers concerned with the same or related sectors of science.

IMPACT ON NIGMS

Question: The National Institute of General Medical Sciences supports two-thirds of the predoctoral trainees funded by NIH.

What impact will the $18 million cut from the NIGMS training budget in 1981 have on predoctoral biomedical research training in the U.S.?

Answer: A policy decision has been made by the Administration to eliminate funds for indirect costs and institutional allowances from biomedical research training awards made under the authority of the National Research Service Act (NRSA). The elimination of institutional allowances alone accounts for $13.1 million of the reduction you mentioned, most of it associated with the predoctoral program. Perhaps more properly called "trainee-related expenses," institutional allowances go to pay the costs of research supplies, equipment, and technical assistance which have been provided in order to strengthen the predoctoral training programs and insure that they are of the highest quality. Only in this way can we expect the trainees to have been given a broad enough background to remain versatile, creative scientists for a long time after they graduate.

The FY 1981 rescission also includes a $2.5 million reduction for NIGMS associated with the elimination of the Institute's indirect cost contribution to the training program. We do not know the impact of this deletion.

An additional $2.9 million has been cut from the NIGMS training budget as part of the decision to reduce the number of trainees supported by NIH from 10,500 to 10,000. NIGMS will now support 292 fewer trainees in 1981 than originally planned, 261 of whom would have been at the predoctoral level.

Question: Don't such cuts discourage bright young students from entering research careers by suggesting a lack of stability in the field?

Answer: We do not know. There is anecdotal evidence that a stable commitment by the Government to research and the unusually long-term, specialized training required for research are important considerations for young men and women in choosing a career.

Question: And, what is the effect of this reduced commitment likely to be on the quality of the nation's predoctoral research training programs?

Answer: We do not know at this time. The final effect will depend on the availability of alternate sources of support for trainee-related costs and for indirect costs which, to date, have been deemed essential in order to provide research training of the highest quality.

CANCER CONSTRUCTION GRANTS

Question. What priority is the National Cancer Institute giving in terms of program priority and budget allocation to construction grants in view of:

-- The impact statement which was prepared by the National Cancer Advisory Board on construction needs across the country;
-- Safety and Biohazard considerations;
-- The ability of the biomedical research community to carry out currently funded research programs in order to maintain a research environment in support of a stable research base?

Answer. The NCI has attempted to follow the intent of the recommendations included in the impact statement prepared by the National Cancer Advisory Board regarding construction. However, within the resource levels available to the Institute other priorities have necessitated that funds be allocated amongst other programs. Of the funds that have been provided for construction, priority has been given to safety and biohazard containment considerations and the Institute will continue to view this as an important area.

Question: In the February testimony submitted to the Subcommittee, Department witnesses testified that Americans spent nearly $15 billion last year on dental care, much of it to repair damage done by dental caries. They futher stated that modified dietary habits of the public would reduce the prevalence, and thus the cost of dental caries treatment.

Last year, Department witnesses stated they were working out a system to screen consumer food items for their decay-causing potential and would compile for the consumer a list of foods most harmful to dental health. However, this year, in the February testimony, they indicated that they were not able to predict when this list would be available.

Inasmuch as this list may reduce, by several billions of dollars the cost of dental care for the American public, shouldn't this research be given a high priority?

Answer: Research in the area of reducing the cariogenic potential of the American diet is one of three major strategy areas in NIDR's National Caries Program and does have a high priority. The particular area includes identifying and characterizing potentially useful non-cariogenic sweeteners and epidemiologic studies to identify the classes of foods that cause most caries for Americans, as well as research into factors that cause certain foods to be much more cariogenic than others. NIDR research in the latter area is focused at present on developing a reliable combined assay that can be used by dental researchers in ascertaining the factors, such as frequency of eating, that contribute to caries, that can be used by food manufacturers to help in developing foods with decreased caries causing potential, and that can be used to distinguish between snacks with high, and low caries potential.

The combined assay being developed in NIDR's National Caries Program consists of two stages of tests so that foods can be screened more expeditiously, so that results can be extrapolated to predict cariogenic effects in humans more closely, and so that the assay can be used with a greater variety of snack items. One of these tests, based on caries increments in rats, now is largely developed; the other, based on measurement of acid generated in the mouth when foods are eaten by humans is not completely developed.

Question: What priority is it given?

Answer: The overall strategy of reducing the cariogenic potential of the American diet has a priority in NIDR's National Caries Program approximately equal to the priority given to each of the Program's three other principal strategies--combatting the microbial agent, which includes developing an anti-caries vaccine; increasing the resistance of teeth, which includes clinical trials of simple-to-use, cost-effective techniques; and transmitting information about useful caries-preventive techniques to the public.

Currently about one-third of the National Caries Program's budget is for contracts and about one-eighth of its direct operations projects are employed in the overall strategy area to reduce the cariogenicity of the American diet.

Question: Are you coordinating this research with other agencies or departments?

Answer: Although the NIDR is not directly collaborating with other agencies in this work, it is keeping the Food and Drug Administration and the Department of Agriculture informed of its activities through seminars and discussions. Also, through liaison representation on the NIH Nutrition Coordinating Committee these agencies are informed of NIDR's continuing activities in this area. The NIDR provides advice to other agencies when requested.

Question: What are the obstacles to consummating the research?

Answer: Progress in developing the second stage (intraoral pH measurement) of NIDR's cariogenicity assay is dependent on the solution of technical problems in obtaining a reliable miniaturized acidity sensor. The NCP is working with several engineering groups to expedite the resolution of this obstacle.

Question: When can we reasonable expect such a list to made available?

Answer: It should be clearly understood that NIDR's research effort at the present time is to complete the development of a reliable assay, including assessment of its characteristics and potential applications. When this phase of work is completed, scientists in academic, commercial and other settings will be using the tool in various approaches to achieve the same objective - reduced cariogenicity of the American diet. Whether at that time the development of a compilation of foods most harmful to dental health should be considered to be the best approach to this objective is not known. Less costly versions of this approach certainly will be considered. One of these would be to identify those food classes and food items such as cheeses that generally are caries safe and to develop principles to guide consumers in the choice and use of snacks to avoid dental caries. Thus, results of the NCP research already have been used to develop educational material on snacks.

EPIDEMIOLOGICAL STUDIES

Question: Do you intend to initiate epidemiology studies in arthritis to try to identify the precipitating environmental factor?

Answer: I understand that the Arthritis Program (NIADDK) at the National Institutes of Health is very much interested in epidemiologic studies in arthritis. In fact, just this past September, the Arthritis Epidemiology Office at the "Arthritis Institute" (NIADDK) organized an International Conference on the Epidemiology of the Rheumatic Diseases with leading clinical investigators in the arthritis field and national leaders in chronic disease epidemiology participating in the conference. Several interesting research ideas utilizing epidemiologic methods were proposed. The discovery of several new genetic markers for selected forms of arthritis provide an excellent means of defining susceptible populations at risk for arthritis. For example, 95 percent of patients with spondylitis (spinal arthritis), that largely affects young men, have the genetic marker, HLA-B27, and there is new evidence that certain specific strains of bacteria may initiate the disease process. One study proposed was to follow young "healthy" men with the HLA-B27 marker, and search for such bacteria when the spinal arthritis begins. We hope to receive research applications along these and similar lines. This type of research offers the potential for gaining knowledge important to formulating programs for disease prevention, in which I am greatly interested.

JUVENILE RHEUMATOID ARTHRITIS

Question: This committee has for the last several years expressed a specific interest in an expansion of research in the field of arthritis in children. What avenues are being pursued by the Institute in this area?

Answer: The Institute has included arthritis in children in its program announcements to the research community as a special area deserving research emphasis. Meetings have been held with the leaders in pediatric rheumatology research to inform them of our special interest in this field and of the various mechanisms available for support of research training and development. In addition, several interesting projects on arthritis in children are being supported in the Multipurpose Arthritis Centers. These include long-term follow-up studies into adult life, basic immunology research, and the initiation of an epidemiology study.

DIABETES CENTERS PROGRAM

Question: Would your research proceed faster if you could expand your centers programs?

Answer: The ability to take advantage of the many new and exciting opportunities for sufficient and rapid advancement in diabetes requires the use of all mechanisms of support of research which are available: investigator-initiated research, centers programs, training and research contracts. Centers provide a unique opportunity to bring together in a concentrated environment scientists and physicians from multiple and diverse scientific disciplines to conduct multifaceted and integrated research which bears upon diabetes mellitus. The centers environment also provides the unique opportunity to integrate multidisciplinary research with training, information transfer and health care activities. Expansion of the centers program will stimulate the overall effort against diabetes. Expansion of all mechanisms of diabetes research will allow faster progress in diabetes research.

Question: What additional areas could the various centers profitably investigate?

Answer: The diabetes centers environment provides a particularly good opportunity to investigate many aspects of diabetes from a multidisciplinary approach. Thus, questions concerning the etiology of diabetes can be addressed in a single setting by virologists, geneticists, immunologists, epidemiologists, pediatricians and internists. Investigations regarding the mechanisms by which hormones act, particularly insulin, can be conducted in an integrated fashion by biochemists, physiologists, molecular biologists and internists. These are but a few of the many areas of research on diabetes that could be profitably investigated within the diabetes centers. The diabetes centers also provide an excellent environment in which to conduct clinical investigation, for example, to study in man the relationship between the metabolic abnormalities of diabetes and the development of the chronic complications of this disease.

CHANGES UNDER NEW LAW

Question: A law passed last year made a number of changes in the Institute, including changes in its name. How will these changes affect your activities?

Answer: The new law will strengthen the Institute organization by formalizing organizational changes which our Institute has undertaken administratively over the course of recent years in order to be able to carry out its rapidly expanding mission.

Question: To what extent will the Kidney Diseases Program get more emphasis?

Answer: We expect the kidney disease program to maintain its current proportional share of the Institute's budget.

Question: How will you implement the recommendation by the conferees that training of allied health professionals be given special attention in the centers programs?

Answer: The Institute will include the proper wording concerning the availability of stipends for health professionals enrolled in arthritis and diabetes multipurpose center training programs in all future center program announcements and in application directions for renewal of existing centers and for the creation of new ones. It is to be expected that the extent of such training will vary from center to center, depending on the local need and on the resources available to each center. Because of the budgetary constraints already at work, most centers must choose their priorities very carefully and the magnitude of their respective activities reflects this reality.

NATIONAL COMMISSIONS

Question: During the past decade, several National Commissions were created to study the state-of-the-art on various diseases and to make recommendations for further research. In each case, increased research emphasis has followed. Do you foresee the need for any more National Commissions such as the ones that studied diabetes, arthritis, and digestive diseases?

Answer: The reports generated by the three national commissions have been of major benefit to the Institute's programs. It is reasonable to expect that commissions studying the state-of-the-art of our other categorical disease areas would be equally beneficial.

Question: Would kidney diseases be a logical candidate?

Answer: Yes. As one of our major programs, kidney disease would be a logical candidate for study by a national commission.

DIETARY GUIDELINES

Question. In light of the amount of dietary information being provided to the American public, what is the Institute doing to reduce the confusion of conflicting information and provide a coherent message to the American people?

Answer. We have two major clinical trials underway which, hopefully, will provide us with new data and shed considerable light on the cholesterol/heart disease hypothesis. One is the Lipid Research Clinics' Coronary Primary Prevention Trial. This 10-year study, scheduled for completion in 1983, involves 4,000 men between the ages of 35 and 59 who are essentially normal, except for the fact that they have elevated cholesterol levels. One of the primary objectives of this clinical trial is to determine whether lowering cholesterol levels will reduce or slow the developement of coronary heart disease. Another clinical trial--the Multiple Risk Factor Intervention Trial or MRFIT--involves 12,000 men between the ages of 35-55. With this trial, we are attempting to see if we can affect a significant reduction in coronary heart disease deaths by lowering serum cholesterol levels, reducing elevated blood pressure, and eliminating smoking. This trial is scheduled for completion in 1982.

We anticipate that the findings of these two trials will help us immeasurably in understanding the association between cholesterol and heart disease. However, when one realizes that there remain today a few scientists who still challenge the link between smoking and heart disease and smoking and lung cancer, we cannot give assurances that any new data provided by these clinical trials will resolve the cholesterol controversy completely.

Cholesterol and its impact on heart disease is a relatively complicated issue and one which prohibits a general public educational approach on a national scale. We do not know what is a desirable level for cholesterol as we know with blood pressure. We cannot assure people, at this time, that lowering their cholesterol level will help prevent a heart attack.

Our approach to countering confusion and giving perspective to the issue is to make available to the health professions and the public information based on what we know, what is suggested, and what we don't know. We do this in a number of ways. Let us give you some examples. For the physician, we have the Dietary Management of Hyperlipoproteinemia, a series of patient education pamphlets and a physician manual which have been distributed in the millions and are used widely in daily practice. These guides deal with specific lipid disorders. For those engaged in nutrition counselling, we, together with the American Heart Association, have staged a series of workshops around the country which will result in a "workshop package" to be further used by many others involved in training nutrition counselors. For the public, we have developed a number of projects and have disseminated a variety of informational materials. Together with Giant Foods, we developed the "Foods for Health" program which provided consumers with basic nutritional information at the point of purchase. The American Heart Association is developing a model based on this experimental project for national distribution through its chapters. Other food chains and businesses have adapted the program for community or employee educational purposes. Our widely distributed booklet on heart attacks, being promoted by tennis star Arthur Ashe, carries a section on cholesterol as one of the risk factors associated with heart attacks, and we have just completed a project with US Air, whereby we provided a column on nutrition and heart disease each month for their inflight magazine.

We are hopeful that in the not too distant future we will have the scientific base upon which to aggresively build a more comprehensive educational program directed at altering dietary behavior and extending life among our citizens. On the basis of available data, we cannot yet aggressively pursue that course of action.

Question. Has there been a change in the research priorities of the Institute in the past year as a result of these dietary reports and, if so, please explain?

Answer. There really has been no change in NHLBI research priorities resulting from the cholesterol controversy of the past year. However, there has been a feeling of reinforcement for our efforts to seek answers to crucial questions about cholesterol and heart disease, as well as for our policy of making factual information available to the professions and the public, based on what is known, what is suggested, and what is not known.

ALTERNATIVE TREATMENT

Question. A prescription drug regimen is the primary method of treatment used to control mild hypertension found in 40-60 million Americans. Since this regimen could last for the rest of the patient's life, what alternative treatment methods, such as behavior modification are you looking at?

Answer. The National Heart, Lung, and Blood Institute is aware of both the costs and risks associated with the life long use of pharmacological agents in the treatment of hypertension. We have, therefore, placed the search for alternative non-pharmacological treatments high on our priority list.

Our interest in this area was presented to the scientific and medical communities in a program announcement entitled, "Biobehavioral Approaches to the Treatment of Hypertension." The response has been gratifying and clearly indicates a recognition of the needs.

The recently completed Hypertension Detection and Follow-up Program has demonstrated the benefits derived from treatment of mild hypertension and has created an even greater need to develop alternative treatment strategies. It is now estimated that 60,000,000 Americans will benefit from research in the hypertension area.

Modification of diet is one non-drug modality that we are fully exploring. We know now that, in some patients, restricting the amount of sodium consumed (usually as salt) can help lower blood pressure. In some patients, weight loss can bring the pressure down. We cannot now tell in advance whether a given patient will be helped by these approaches, nor are we certain (although it seems very likely) that this way of lowering blood pressure also lowers risk. We do not now fully understand what physiological mechanisms are altered by these approaches. For example, in at least some persons, the ratio of sodium and potassium eaten may be more important than the absolute amounts consumed. The way the body handles sodium may be different in obese people and slim people. Recent research has detected differences in sodium movement into and out of red blood cells in hypertensive and normal persons. We are not yet sure, however, whether or not this is an important clinical indicator. The Institute is supporting a large number of investigations examining these and other related questions.

Exercise is another modality of interest. Some hypertensive patients experience a modest blood pressure reduction when they exercise regularly. A portion of this effect may be due to weight loss, but some patients end up with lower pressure even though their weight stays the same. The role of exercise in lowering blood pressure is also under study.

Perhaps the most talked about non-drug treatments are the psychological approaches: relaxation training, stress reduction, biofeedback, yoga, and similar methods. Although these are being investigated, it is important to note that they are exceedingly complex research questions to explore because it is so difficult to separate out the so-called placebo effect.

Our interest in these alternatives is great for several reasons. Each alternative offers a different view on the causes of hypertension and, therefore, relates to our ultimate goal of preventing rather than treating hypertension. Secondly, no drug is totally free from risk. If we can treat hypertension effectively through non-drug therapy, everyone benefits. And, we are certainly very sensitive to cost issues. If a diet program can have the same outcome as using a drug, we certainly have more cost effectiveness, provided the benefit is the same or better.

That brings us to the most cogent questions on this issue. First, we must answer the question of whether an alternative treatment to drug therapy can sustain a significant lowering of blood pressure. Secondly, we must be sure that blood pressure lowering by way of an alternative treatment also lowers the risk of death and disease as effectively as currently used treatments.

We do not have answers to all these questions as yet. Therefore, all these alternatives must be considered experimental, especially as primary therapy for moderate and severe hypertension. In these two cases, we must continue to use medication in high risk subjects until we have very clear evidence that alternate approaches can result in the same benefit.

RESEARCH TRAINING

Question. We understand there were 630 clinical investigators in the Heart Institute's training programs in 1972, but this number dropped to 295 in 1979. What was the reason for this reduction?

Answer. Factors playing a role in the decreasing number of clinical investigators include:

. the fluctuation of the level of available training funds in the 1970s.

. research support decreased in some institutions resulting in considerable concern about support of active investigators.

Clinicians considering the possibility of research careers would be discouraged by the general concern about the national goals relating to biomedical research.

- debts resulting from the escalating cost of medical education continue to increase and are added to the expenses of living, which often includes a family in the case of the young physician. Research training delays the payback of debts which increase because of the interest accumulation. Pressures from family and lending agency strongly discourage continued postponement of the debt retirement.

- payback obligations built into the NRSA trainig programs require a period equal to the months of stipend support in full-time research and/or teaching. Individuals who do not obtain acceptable positions are subject to financial payback unless alternative payback is justified and granted.

- stipends were unchanged between 1974 and 1980, despite the continued inflation. Stipends are not competitive with other options available to physicians.

Question. Is there sufficient money available to you this year to maintain your training effort? If not, what do you recommend?

Answer. The budget as originally approved by Congress for 1981 provides sufficient funds for research training to adequately fund the most meritorious submitted applications. However, the possibility of a rescission proposal which would reduce the number of trainees by 8% (131) and delete traditional institutional support and indirect costs, leaves the future of these training programs in question.

Question. To what degree could the states assist in funding research training?

Answer. The states already provide the major support for facilities, faculty, and personnel salaries and indirect costs in the state institutions. Over three-quarters of institutional research training support is currently being borne by local institutions, particularly state university medical schools.

HEADACHE PAIN

Question: Two recent NIH studies, the Report of the Panel on Pain and the Interagency Report to the White House on New Therapies for Pain and Discomfort have indicated that vast numbers of Americans suffer from severe and disabling headaches commonly known as migraine headaches. The Interagency report states such severe headaches attack some 24 million people at a cost to the economy of $8.2 billion per year. The Report of the Panel on Pain arrived at a somewhat smaller figure - 6 million men (12% of the total) and 10 million women (18% of the total) are subject to severe or disabling headaches.

Given that pain cannot easily be quantified from one individual to the next, I am seriously concerned at the apparent magnitude of this problem. What specific programs are currently underway or planned at NIH to address the cause and treatment of headache pain?

Answer: The National Institute of Neurological and Communicative Disorders and Stroke supports a variety of studies related to pain, including chronic pain and headaches. Many of these are fundamental investigations intended to delineate the pain receptors, neural circuits, nerve transmitters and other substances (e.g., endogenous opiates) that comprise the many elements of the pain system. Relevant areas include the nerve supply and neurohumors of the blood vessels, constituents of the blood, and the functioning of the autonomic nervous system controlling the blood vessels of the head. Even where research is directed at disorders other than headpain, it can be anticipated that many of the findings related to pain will be applicable to chronic headache as well.

The Institute, in addition to the studies mentioned above, has maintained a continuing interest in the processes contributing directly to chronic headache, as well as promising therapies to alleviate the discomfort. The extent of the research supported is exemplified by the following activities. A recently completed study in patients assessed muscle-contraction headaches and migraine headaches and characterized muscle activity, tissue temperature and psychophysiological profiles of headache sufferers. Ongoing studies include evaluation of means to avoid or minimize headaches through behavioral modification, including temperature feedback, relaxation training, and psychotherapy. Individual differences in perception, as related to pain, are under scrutiny in an attempt to understand why several individuals with the same disorders may manifest anywhere from little or no pain to extreme, unremitting discomfort. Other projects are directed at the pharmacologic (drug) modification of pain. A recently instituted clinical study is endeavoring to evaluate and optimize drug therapies in the treatment of migraine headache.

The Institute is currently preparing a Program Announcement on chronic pain that is intended to stimulate further efforts in pain research including those aspects related to headache.

The NINCDS Office of Biometry and Field Studies (OBFS) has been conducting research on the national problem of severe and disabling headaches. It has been involved with the Panel on Pain and has held a meeting in April 1981, with the leading clinical researchers in the field of headache pain. As a result of this meeting, the OBFS has been preparing plans for a National Headache Survey. The purpose of this survey is to describe the magnitude and extent of the headache problem in the U.S. population and to study the factors associated with headaches. The survey will be based on self-reported information from a national probability sample of households.

EFFECTIVENESS OF ADAMHA SERVICE PROGRAMS

Question: The Administration is proposing to include, in its health services block grant, the service components currently positioned in the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA). How successful do you believe Federal alcohol, drug abuse and mental health programs have been in addressing these problems?

Answer: We believe the present ADAMHA service programs have been very successful over the years in addressing alcohol, drug abuse and mental health problems. In the area of mental health, for example, the system of Community Mental Health Centers (CMHCs) initiated in 1963 has been instrumental in making a wide range of low-cost services available to many previously unserved persons, and specifically to assist in patient deinstitutionalization. This system is now the major alternative to State hospitals and other long-term care facilities. The drug abuse and alcohol service systems, while established more recently than the CMHCs, have made specialized treatment services much more widely available outside the acute care hospitals. In all problem areas, three service demonstration projects have helped determine the most effective treatment methods and have formed the basis for development of full-scale service programs. We feel confident that under the block grant proposal, the States will continue those efforts which they deem to be most successful and necessary.

PUBLIC OPINION OF MENTAL ILLNESS, DRUG ABUSE AND ALCOHOLISM

Question: Isn't this an indication to the American public that the Federal Government no longer views as critical the problems of mental illness, drug abuse and alcoholism?

Answer: I hope that the American public would not get that impression, since it is most certainly not the case. We see the problems of mental illness, drug abuse and alcoholism as of continuing importance, and are still recommending a strong Federal rôle in addressing several aspects of them. Both extramural and intramural research programs will be continued in 1982, since there are few private sources of financial support for them, and related training and other national leadership responsibilities would be maintained. Moreover, the Federal government would still be providing a large amount of financial resources to the States for conducting direct treatment, prevention, and other service programs. We are simply suggesting that the focus of administrative control and responsibility is more appropriately placed at the State level, not that the problems are any less important.

Senator Inouye: As you are aware, this subcommittee has been gravely concerned for some time that the National Institute of Mental Health has not been meeting its verbalized commitment to train a sufficient number of minority mental health professionals. In fact, in P.L. 96-304, your Department's Supplemental and Rescission Bill for 1980, we included express language directing the National Institute of Mental Health to increase its financial support for the Minority Fellowship Program from $2.5 million. However, the committee understands that this has not been done. Further, we understand that under proposed NIMH guidelines for both your research and training programs, this particular initiative will soon essentially be totally phased out. This is in spite of our Committee's interest in the program and the fact that the Minority Fellowship Program has the strong and enthusiastic support of each of the four traditional mental health disciplines and the American Sociological Association. In its seven years of existence the Minority Fellowship Program has successfully produced 141 qualified minority mental health professionals and apparently has 255 additional students currently being supported. Accordingly, the committee would appreciate your personal assistance in providing us with information on the status of the Minority Fellowship Program.

Answer: The Minority Fellowship Program is part of both the clinical and research training programs of NIMH, and as such is being treated exactly like the broader programs. While additional funds were budgeted for the Minority Fellowship Program by NIMH in 1981, as directed by Congress, these funds have not been spent because of the Administration's rescission request.

In clinical training, no new or competing renewal awards are being made. This will impact on one of the five grants in the Minority Fellowship Program in FY 1981. Two additional grants will terminate at the end of that year, and all clinical training programs are scheduled to be phased out by the end of 1982.

In research training the National Institute of Mental Health is in the process of assessing the appropriateness of funding training in social research which is not directly relevant to mental health problems. The present plan is not to fund programs in this category, and each of the minority fellowship grants will have to be assessed for the content of training. Any awards that are made will be funded at a reduced level, since only student support, not institutional (or in this case professional association) costs will be paid.

MENTAL HEALTH/UNDERSERVED POPULATIONS

Question: Among the priority groups now considered underserved, as outlined in the Mental Health Systems Act, what percent do you estimate as being underserved because services are not physically accessible to them, such as in rural areas?

Answer: We estimate that about 50 percent of the underserved are being underserved because services are not physically accessible to them.

Question: What percent are underserved because the system is not able to take care of their needs, such as the elderly and chronically mentally ill?

Answer: National statistics of the percent of each underserved population are not available. A review of State findings, however, indicates that between 60 percent and 90 percent of the population had some service needs which were not being met. The greatest unmet need was for residential services. Other services in short supply were psychosocial rehabilitation, vocational rehabilitation, mental health services, case management and advocacy and basic health care.

COMMUNITY MENTAL HEALTH CENTERS

Question: How many Community Mental Health Centers are there currently receiving Federal support?

Answer: Currently, 497 CMHCs are expected to receive Federal support in FY 1981.

Question: On the average, what percent of their total operating costs is provided through Federal dollars?

Answer: Excluding reimbursements from Medicare/Medicaid the percentage of operating costs are approximately twenty-five percent.

RESEARCH/NEW AWARDS

Question: For what purposes will new research awards be made in fiscal 1982?

Answer: Research of the National Institute of Mental Health will be targeted to research on the major mental illnesses, children, and the elderly. In the area of schizophrenia, research will be supported for the purpose of developing more effective medications for patients previously thought to be treatment resistant. Depression studies will be directed toward further understanding of the genetic mechanisms and specific sub-types of depression for which there is a risk of transmission through heredity. A major research priority will continue to be the reduction of adverse side effects produced by some of the more widely used anti-psychotic medication.

In the area of childhood mental illness, an initiative in childhood depression will be directed toward increasing cumulative research on the etiology, epidemiology, and criteria for diagnosis and treatment.

Finally, in 1982, a program will be launched to develop an effective somatic treatment for senile dementia. Newly developed drugs which appear to be particularly successful in treating the elderly depressed patient will be evaluated in a multi-state, collaborative study. The purpose of this study will be to compare the relative effectiveness and toxicity of one of the newer anti-depressants with a standard drug in current use.

In FY 1982, the National Institute on Drug Abuse's new and competing research awards will be made for the following purposes:

EPIDEMIOLOGY

- To develop a method to assess emerging drug abuse patterns among special populations;
- To study adolescents use of "gateway" drugs such as cigarettes, alcohol, and marijuana;
- To field test and implement a nationwide survey on the consequences of marijuana use in adolescents;
- To conduct a survey on drug use and misuse among the elderly;
- To implement a five-year followup of drug use patterns among selective service registrants; and
- To conduct a nationwide followup of addicted mothers and their children.

ETIOLOGY

- To study endogenous opiate-like substances and opiate receptors;

- To study the commonalities underlying all kinds of compulsive behaviors;
- To develop new computer methodology for determining cause and effect relations in drug using behaviors; and
- To study basic mechanisms of nicotine addiction and withdrawal.

HAZARDS

- To conduct a major chronic marijuana inhalation study;
- To study the effects of heavy marijuana use on the immunological, endocrinological, and pulmonary systems; and
- To conduct research on the smoking of cocaine free base and smoking as a mode of administering drugs of abuse. We will support a new research center concentrating on investigations into marijuana abuse.

PREVENTION

- To develop and assess effective prevention strategies.

TREATMENT RESEARCH

- To initiate Phase I studies of buprenorphine, a new therapeutic agent with great potential, as an agonist/antagonist for treatment of drug abuse;
- To initiate Phase III investigations of our most promising narcotic antagonist, naltrexone;
- To investigate clonidine as a new and potentially very useful tool for use in withdrawal from narcotic addiction; and
- To conduct the additional animal studies required to obtain FDA new drug approval for LAAM, which has special advantages over methadone for treatment of narcotic addiction.

BASIC RESEARCH

- To expand research on endorphins, on the neurobiology of euphoria and dysphoria, on the reinforcing properties of drugs, on neuroendocrine function and drug abuse, and on biological factors predisposing to drug abuse. We will support a new research center focusing on studies of endorphins; and
- To study the feasibility of using PETT scanners for the study of the neurophysiology of addiction and dependence.

TREATMENT ASSESSMENT RESEARCH

- To develop models of quality service programs and methodologies for the evaluation of treatment program effectiveness.

GENERAL RESEARCH SUPPORT

- To develop a new methodology for testing and synthesizing endorphins for scientific research, a new technological development upon which much of the research in the area of endogenous opiates depends. The development of new testing assays for marijuana and PCP will be supported;
- To conduct intensive review of drug abuse impact on the family;
- To develop a reliable and accurate breath test for marijuana convenient for mobile use (e.g., testing of erratic drivers).

In the National Institute on Alcohol Abuse and Alcoholism, new research awards will be made in 1982 to expand research into the inherited factors which lead to alcoholism; the effects of alcohol upon the brain and other organs and the relationship of alcohol abuse to such health problems as heart disease, cancer and malnutrition; the development of diagnostic techniques which can be used by physicians and others in the health care field; the development of improved treatment methods and basic techniques useful in the prevention of alcoholism.

SOCIAL SCIENCE RESEARCH

Question: It is a generally held belief that many factors contributing to the abuse of alcohol and drugs relate to sociological phenomenon--peer groups, economics, familial, and other external rather than biological factors. In light of the sociological influences associated with these problems, how can you justify the termination of social science research for alcoholism and drug abuse?

Answer: The current budget request for alcoholism and drug abuse research supports the President's plan for economic recovery by focusing on the biomedical aspects of substance abuse and phasing down studies on its social ramifications. In the past, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) has sought to understand, treat, and prevent alcoholism and drug abuse through emphasis on the need for knowledge about biological, psychological, and social factors which accompany these disorders.

It is not our purpose to terminate the social aspect of this approach but to make certain all activities in this phase are directly related to the biological and psychological factors. In other words, our intention will be to exclude research that is directly focused on social issues whose exclusion will not adversely affect legitimate attempts to explore problems crucial to an understanding of substance abuse.

Question: There has been some criticism about laboratory research in the social sciences being out of touch with problems being investigated in the field. Do you see the need to distinguish between these two types of research?

Answer: In most fields, strickly controlled laboratory research provides the basis for theories and methodologies that underpin clinically-oriented and applied research. In an agency like ADAMHA, that deals with mentally focused diseases, the controls cannot be as precise because the subject is less defined. That makes the research no less valid, only more difficult. To further distinguish does not seem helpful; what is more important is to assure that what is researched is directly related to the field. There is a need to attend to the balance of the overall research portfolio, including the relative emphasis on different scientific fields, and within those fields, the types and styles of research being done. However, it is often difficult to distinguish these types of studies; often, a given project includes both some laboratory studies and some field work.

Question: Do you see any justification for reducing "remote" or ivory tower, institutional research but to protect some of the research being done in close proximity to the problem or population under study?

Answer: It is important for the Nation to maintain a balanced well-rounded scientific effort, focused on health and other national problems. It is a natural result, in times of economic belt-tightening to review the scope of research being done and to take a closer look at how their support relates directly to the mission and problems the agencies are trying to solve.

Question: Do you have any expectations that the private sector will be willing to pick up where the Federal Government leaves off?

Answer: I don't feel that we are "leaving off" a great deal here. Our proposal will maintain and even increase in 1982 over 1981 the level of research in this area that is directly pertinent to the mission of the agency. What remains will be picked up by other sources if it is viewed as productive. It is, in balance, unlikely that the private sector will pick up much support for social science research. While interest in working more closely with the private sector in the research area is growing, such efforts are most likely to be fruitful in high technology areas. Although social science has contributed to such diverse areas as agriculture, aviation, worker productivity, and economic and business methods, there is little indication that private sector will be forthcoming.

Question: Since the Administration has been stressing disease prevention, isn't this a contradiction between stated priorities versus actual policy?

Answer: There is less contradiction than may appear on the surface. It is true that many prevention oriented programs in health, mental health, and substance abuse do involve social factors. However, ADAMHA does expect to continue prevention research that will involve a variety of biological, psychological, and social factors.

BLOCK GRANTS/SPECIFICS

Question: Last year, as you know, Congress enacted the Mental Health Systems Act, which authorized several new project grants to support special mental health problems, and the chronically mentally ill, severely disturbed, minorities, elderly, etc. These groups were targeted in large part because they had been so neglected by mental health programs in the past. To what extent will the health services block grant proposal include any provisions to assure that the needs of these special groups will be addressed by the States?

Answer: The block grant proposal as submitted to Congress contains no earmarks or other provisions to assure that States will meet the needs of these special population groups. However, we believe that the States, being much closer to the problems of these special groups, will be responsible in addressing their needs. The States will be able under the block grant proposal to establish their own priorities and establish programs that will effectively address the needs of the special groups.

Question: What is your sense as to the way States will allocate funds for each of the three programs--alcoholism, drug abuse, and mental health? Do you envision that when the "blocks" reach the States they will be transferred to mental health agencies to administer for all three programs?

Answer: It is difficult to project how the States will distribute funds for the three programs, as this will vary significantly among the various States. I assume that each State will develop a planning process and project application review system which will permit such resource allocation decisions to be made at the highest levels, if in fact such systems are not already in place. In addition, it is unlikely that the entire block grant would be transferred to the mental health agency since it will be a general health grant. Most States will probably distribute block grant funds among the various administrative agencies in the health area according to decisions made in the overall health plan. Of course, in those States where the mental health agency is also responsible for addressing drug abuse and alcoholism concerns, that agency would be the logical recipient of funds for all three program areas.

Question: If so, what guidelines are necessary to assure that funds are directed to the areas with the most severe problems?

Answer: A fundamental change that will take place with the implementation of the health services block grant is that States will be given the responsibility for planning, coordinating, and providing needed health services to their recipients. As part of the planning process, the States will identify those areas with the most severe problems, and in establishing their priorities, will want to target funds to those recipients who are best with those problems. We feel that, consistent with this philosophy, no guidelines such as those you mentioned are necessary.

Question: In your judgment, which programs are likely to be neglected by the States under a block grant situation?

Answer: It is impossible to predict which programs will be emphasized by the States and which will not. Through the planning process, each State will establish its own funding priorities for health services and support those programs deemed to be most essential. For example, while one State may emphasize support funding for a specific population group, such as the elderly, another State may determine that support services for the chronically mentally ill are of higher priority for funding. We expect that no area needing strong and continued funding support would be simply ignored or neglected by the States.

Question: Doesn't the whole concept of block grants mean that a lot is going to be left up to the political realities at the State level--and that the "safety net" might fail for needy groups without political clout?

Answer: It is true that public interest groups representing the elderly, the chronically mentally ill, and other priority populations must work closely with the States to make their specific needs known. They will be competing for scarce health resources at the State level with those representing other interests just as they must now do in order to receive strong consideration for health funding. This political reality does not, however, undermine the whole concept of block grants, which is simply to transfer responsibility for program decisions and administration to the States. We expect that continued funding support for those in strong need of health services will be a high priority with the States just as it is with the Federal government.

Question: Would the States be required to submit reports on how their block grant funds are being allocated?

Answer: Under the proposed block grant program, each State would be required to submit a report on the intended use of the formula funds to be allocated during the year. Secondly, each State would be required to submit a complete record of the purposes for which the funds were actually expended. In addition, each State shall be subject to periodic audits concerning its expenditures under this program. Such audits would be performed by an independent entity.

Question: What leverage should the Federal government have if it becomes apparent that certain needs are being neglected by the States?

Answer: Under the proposed block grant program the States will have full and total responsibility for allocating funds according to their individual health care priorities. This philosophy precludes the Federal government from making decisions as to how the States are addressing health needs within the States, for we must assume that their decisions will be rational and in the best interests of the State residents. We have not therefore included in our proposal the type of override provision to which you refer.

Question: Would the States be required to submit reports and statistical data on the health services programs funded by the block grant so that the three Institutes within ADAMHA will have some feedback on developments in their areas?

Answer: No formal statistical data reporting is currently envisioned as part of the block grant program. Each of the three Institutes of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) will continue to maintain epidemiological data including incidence and prevelence rates of these three health problems. We hope that States would continue providing input to these programs, but their awards would not be predicated on any such requirement.

Question: What will become of the ADAMHA Institutes' roles as Clearinghouse for information on Alcoholism, Drug Abuse, and Mental Health?

Answer: The role of the National Institute of Mental Health clearinghouse will be maintained. It is important to maintain a function which can translate research findings into information which is useable by the mental health community.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) will continue the activities of its clearinghouse which serves a crucial national role in maintaining a comprehensive data base of alcohol literature and disseminating information to the professional community and the general public. The funds to continue this effort have been requested under the program support budget line item in FY 1982.

The National Institute on Drug Abuse's clearinghouse activities will continue. This activity is supported with program support funds and will not be directly affected by the block grant proposal.

MONITORING

Question: With single State agencies assuming much of the monitoring function for alcoholism, drug abuse, and mental health programs, how do you determine how well they are doing? In other words, how do you monitor the monitors?

Answer: The National Institute on Drug Abuse's Division of Community Assistance (DCA) and the Grants Management Branch (GMB) monitor the Single State Agencies (SSAs) in several ways.

DCA project officers do onsite monitoring of the SSAs which includes sampling a few treatment programs to ensure that NIDA funds are being properly utilized. On these visits, project officers use a monitoring guide to provide uniformity in approach. The Division also employs the services of a contractor, Touche-Ross, to perform program management reviews and State assessments which are later acted upon by the Project Officers. In addition, the SSAs submit to DCA monthly utilization information and periodic performance evaluations.

GMB monitors the States' financial, contract, personnel, property, and information management systems through site visits and review of form submissions.

The products of DCA, GMB, and the contractor's monitoring efforts are reviewed by Institute staff throughout the year to determine the level of State compliance with Federal standards.

The National Institute on Alcohol Abuse and Alcoholism has developed information systems which provide monitoring of alcoholism programs at both the State and local levels. Those systems have been in use for several years and have proven capability and reliability. The systems and their purposes are:

National Alcoholism Program Information System (NAPIS)

NAPIS provides information at the program level on clients, services, treatment outcome and funding. Unit costs and staffing data also may be operated. This system is ten years old and is in use by both NIAAA projects and several States to monitor alcoholism treatment programs. NIAAA is revising NAPIS for greater flexibility and will assist other States to implement NAPIS or similar systems. The Institute can obtain detailed monitoring and research data from States with NAPIS-like systems.

State Alcoholism Profile Information System (SAPIS)

Monitoring of non-treatment alcoholism programs and activities has been fostered through the SAPIS surveys on an annual basis. All States provide data on funding sources and expenditures for prevention, treatment, training, research, and other alcoholism-related activities. Data also are provided on credentialling of programs and staff, new program innovations and accomplishments. Information from other sources on arrests and mortality from alcoholism and alcohol consumption by State is added by NIAAA to assist in examining changes and determining trends. It is intended that SAPIS will be continued.

National Drug and Alcoholism Treatment Utilization Survey (NDATUS)

A joint survey by NIAAA and NIDA is conducted on a bi-annual basis to gather treatment and utilization information in both the public and private sectors. Two such surveys have been completed. Data represent caseload on a specific day, along with funding and staff turnover for the year.

NDATUS provides information on the universe of treatment activities, their location, and client characteristics. NDATUS is less detailed than NAPIS but is very useful for monitoring trends and providing general treatment, utilization, and funding data.

The function of monitoring mental health programs by State agencies was planned in conjunction with the implementation of the Mental Health Systems Act in 1982. Since the States are currently not directly involved in monitoring the mental health services programs funded by the Federal Government there is currently no reason to monitor the monitors.

We will, of course, maintain a capacity to make available to those who request it, technical assistance and consultation with respect to the setting of standards of performance, and evaluation and monitoring methods.

Question: What type of monitoring is planned to insure that those who are considered most in need of services are receiving them?

Answer: The direct responsibility for this type of monitoring would be at the State level. We would strongly urge the States to establish effective monitoring programs to ensure the most expedient use of both Federal and State funds in the areas of alcoholism, drug abuse, and mental health. In addition, ADAMHA will continue to collect epidemiological and service-related data in cooperation with the States.

PROPOSED TRAINING LEGISLATION

Question: Your prepared statement mentions the intention to refocus Federal aid for the training of health professionals and that legislation will be proposed to target limited support on national priority and non-physician specialities. What will your legislation include?

Answer: The legislative proposal to which you refer is in the process of development. However, this proposal would exclude support for activities previously conducted under the mental health clinical training program. This program, along with the drug abuse and alcoholism clinical training programs, is proposed for total elimination at the end of 1982.

INCLUSION OF TRAINING PROGRAMS IN BLOCK GRANT

Question: Is there a plan to incorporate manpower training into a block grant to the States in the near future?

Answer: There is currently no plan to develop a training block grant.

BLOCK GRANT FUNDING

Question: The Administration is proposing for inclusion in the Health Services Block Grant all Alcohol, Drug Abuse, and Mental Health Services now existing in the three Institutes of ADAMHA. It is stated that these programs would then be funded at 75% of the current service level for Fiscal 1981. By current services, do you mean the final Fiscal 1981 level after rescissions or the 1981 continuing resolution level?

Answer: The definition of current services we have used is the 1981 continuing resolution level, that is, the budget level before rather than after the proposed rescissions.

Question: Would the consolidation then include funding for the drug abuse and alcohol state formula grant program slated for elimination by rescission in Fiscal 1981?

Answer: Yes, funding for the alcohol and drug abuse formula grant programs is included in the dollar level of our block grant proposal. As in the case of our directly supported service programs, the amount in the block grant is 75% of the continuing resolution level for the two formula grants.

CLINICAL TRAINING

Question: What is the rationale for the elimination of clinical training by Fiscal Year 1983?

Answer: There is an overriding need to bring the national budget into balance, and this factor forces us to choose our priorities carefully. Although the support of mental health training is an appropriate and desirable activity, it represents an area of national effort which can be continued by the private sector. The Department will continue to support training in areas of greatest national need, particularly where there is reason to believe that the non-Federal sector lacks the resources or incentives to make the necessary progress.

Question: Who will be hurt the most by this proposed elimination of clinical training over the next two years?

Answer: The major thrust of mental health clinical training has recently been to increase the supply of mental health practitioners for service to previously underserved segments of the population. These groups include users of public mental health facilities, minorities, children, and the chronically mentally ill. Through the efforts of these programs, many training institutions have redesigned their training curricula to provide specialized training for service to these groups. For this reason, it is our expectation that these programs will continue to function, and that no single group will be hurt most as a result of the phasing out of Federal training support.

MENTAL HEALTH MANPOWER

Question: Your prepared statement mentions the intention to refocus Federal aid for the training of health professionals and that legislation will be proposed to target limited support on national priority and non-physician specialities.

Specifically, what do you foresee as the ongoing role of the Federal Government in the area of mental health manpower training?

Answer: None. We would see our role limited to research training activities.

Question: What types of training programs would be needed to enable paraprofessionals to perform some of the mental health services, in shortage areas, that traditionally have been performed by professionals in the four mental health disciplines (psychiatry, psychology, psychiatric social work, psychiatric nursing)?

Answer: No type of program short of full fledged professional training would be sufficient to accomplish the mental health work necessary in shortage areas. While paraprofessionals have been and will continue to be very important in mental health service delivery, their role is one of supplementing, not replacing professionals. The position of this Administration is not that lesser trained people can or will be adequate in shortage areas, but that the growth in supply of professionals, along with sufficient inducements from rural and other shortage areas, will attract professionals to these locations.

Question: What will be the effects of the proposed elimination of institutional support payments?

Answer: These funds presently account for only about 25 percent of the total grant, and generally go toward faculty salaries or costs incidental to the training, such as computer time, research equipment, etc. The universities will have to pick up these costs from other public or private sources.

DEINSTITUTIONALIZATION

Question: What portion of the mental health budget is aimed at getting individuals out of institutional settings?

Answer: Support for deinstitutionalization cuts across all segments of our budget. For example, recent research findings will help reduce the relapse rate among previously hospitalized mental patients. During 1980, we spent approximately seven percent of our clinical training budget ($5,401,000) on programs to train individuals to deal with deinstitutionalized, chronically mentally ill patients. Included in the services amount is $7.331 million that is specifically earmarked for programs to allow the chronically mentally ill to leave institutions. This represents about 2.5% of our total services budget. Our entire services program is oriented toward keeping individuals out of institutionalized settings, who might without mental health services need to be institutionalized. Funds which were directed for this effort amounted to $293,801,000 in 1980. The combined training and services effort in this area constitued 55 percent of the entire NIMH budget in 1980. The percentage is probably higher, but it is difficult to assess the specific dollar investment in the research area.

Question: Describe deinstitutionalization programs planned for Fiscal Year 1982.

Answer: The major share of the Institute's effort in that area has been derived from its clinical training and service programs. Since clinical training programs are being phased out in 1982, and service programs are proposed for conversion to a general health service block grant in 1982, it is expected that there will not be a discernible program at the Federal level.

Question: What precautions are being taken to insure that individuals are not just being thrown out into the street, but are provided essential supportive services?

Answer: Last year, NIMH provided Community Support Program (CSP) grants or contracts to 17 States, averaging approximately $350,000 per State. The States in turn used these projects to define the problems concerning discharged mental patients within their State, to clarify State level responsibility for solving the problems, to organize local community services in a more effective way, and to improve their State policies and plans impacting on the chronically mentally ill.

Some of these States established local demonstration areas where they tested different approaches to organizing services for discharged mental patients, in an effort to help these people readjust to society. The local demonstrations also are finding ways to assist and support families, neighbors, employers, landlords and others affected by the presence of mentally disabled persons in their midst. The local demonstrations are testing various approaches to organizing and more effectively using currently available resources. An evaluation strategy is underway to determine the effectiveness of different approaches under different circumstances.

Current legislation requires that CMHCs work with public mental hospitals to provide follow-up care for patients discharged to the community. In States with CSP projects, the staff of the State mental health agency is working with hospitals and CMHCs to improve linkages, assure that effective follow-up and related support services are provided, and to increase community involvement in developing opportunities and services for discharged patients.

RAPE

Question: In the past few years, the Federal Government has funded research and services associated with the serious problem of rape. How much has the Federal Government spent on mental health research associated with rape over the last five years?

Answer:

FY 1976	$1.4 million
FY 1977	2.0 million
FY 1978	1.8 million
FY 1979	3.3 million
FY 1980	2.6 million

Question: What have we learned about the incidence of rape from this research?

Answer: The most recent FBI Uniform Crime Reports (Crime in the United States 1979, Washington, Government Printing Office, 1980) indicates that 75,789 women reported forcible rapes, assaults, or attempts to commit rape by force or threat of force in 1979. The number of reported forcible rapes of women in 1979 was up 13 percent over 1978 and 35 percent over 1975. Of all reported offenses in this category during 1979, 76 percent were rapes by force. Attempts or assaults to commit forcible rape comprised the remainder. Forcible rape, a violent crime against the person, has been recognized by law enforcement experts as one of the most underreported of all Crime Index Offenses, primarily because of victims' fear of their assailants and their embarrassment over the nature of the crime. A high proportion of this group was black and middle or low socio-economic status. These percentages repesent findings from the first of five years of data collection.

Dr. Mary Koss, in her work "Hidden Rape on a University Campus," reported on the experiences of 332 university women. Five percent of these women reported the use of force by men to obtain intercourse. Although intercourse obtained through the use of force is legally defined as rape, slightly less than half of these women acknowledged their experience of intercourse by force as rape. Psychological coercion was reported by 16 percent of the sample and threats of force by two percent.

Dr. Diana Russell, in her work "The Prevalence of Rape and Sexual Assault," examined the incidence and prevalence of rape and attempted rape in San Francisco. Twenty-six percent of the subjects in this sample experienced one or more serious incidents of unwanted intercourse in their lifetime with a range of perpetrators. Five percent of the women reported a sexual assault by a stranger and six percent reported sexual assault by either family or husbands. The balance of these women's sexual assaults (15 percent) are accounted for by acquaintances or by intimates such as lovers, dates, boyfriends. Of those who reported stranger-to-stranger rape, 38 percent reported having experienced a single incident, while 45 percent reported two incidents, and 17 percent reported three or more. The victims of stranger rape are more likely to report multiple incidents.

Question: Will the Federal Government continue to support mental health research to understand the causes and prevention of rape in Fiscal Year 1982?

Answer: We expect to continue our support for this program. The 1982 funding level will be 1.2 million, reflecting our planned phasing down of support for research on social issues; however, this area still has several facets which will continue to be the subject of research.

MENTAL HEALTH SYSTEMS ACT

Senator Chiles: When you served in the Senate on the Labor and Human Resources Committee, you were very instrumental in the development of the Mental Health Systems Act. I'd like to take this opportunity to commend you for your work on that legislation, particularly in seeing that the Senate version, and later the conference report, contained strong, workable provisions for special services to the elderly in the community and institutions.

I'm sure you are aware that hearings by the Special Committee on Aging affirmed the severe lack of services to the elderly under the current system and the crucial need for outreach, differential diagnosis, professional training, and services in locations where the elderly are. There was wide consensus that the provisions of the Mental Health Systems Act went a long way toward addressing these needs.

What is the current status of the development of regulations to implement the Mental Health Systems Act?

Answer: On March 16, the NIMH forwarded to my office a complete package of draft guidelines, regulations, and program announcements to implement the Mental Health Systems Act. This package of materials is under review for comment by the various principal operating components of the Department. We will hold the package until the Congress has made a decision on the health services block grant legislation.

Senator Chiles: Does the Administration plan to recommend repeal of the legislation as part of its proposals for health services block grants? How would you see the needs of the elderly and the chronically mentally ill being met under the block grant approach?

Answer: The Administration's proposed health services block grant legislation includes the repeal of the Community Mental Health Centers Act and the Mental Health Systems Act along with the other Public Health Service legislation superseded by the block grant.

The Administration feels that the States will be responsive to the needs of the elderly and chronically mentally ill as they have been before; and that at the State level the public interest groups representing the elderly and chronically mentally ill will work with the State to make the needs known.

Senator Chiles: I know the Aging Committee hearings pointed out problems in delivering adequate mental health and support services created by restrictive Federal programs, which some sort of consolidation with greater flexibility of State and local agencies could be expected to help relieve. However, should there be some kind of targeting of funds or performance criteria included in the block grant legislation to make sure we don't continue to fail to provide the kinds of services the elderly and the chronically mentally ill need?

Answer: The Administration feels that the health services block grant legislation should not provide for any targeting of funds, be they for elderly, chronically mentally ill, or migrants. It is our belief that the States are much closer to the issues and can better make these decisions on how funds should be used or targeted. Again the State with input from the public interest groups can plan rationally, coordinate service programs and establish their own priorities.

ST. ELIZABETHS HOSPITAL RESCISSION

Question: The Administration is requesting a rescission of $1.5 million for St. Elizabeths Hospital construction. Absent these funds, how will St. Elizabeths be able to pay for necessary repairs and improvements? Are funds available from prior years? If so, how much is still available and why are these funds remaining?

Answer: The hospital will be able to support the highest priority projects through the use of funds available from prior years. At the start of the current year, a total of $46,623,000 was available from prior year balances. The major portion of this balance was appropriated for projects related to accreditation of the hospital. The Congress appropriated these funds in a single increment, so that the hospital would have the flexibility needed to negotiate with contractors and establish timetables which would permit orderly renovation, without undue displacement of patients. At the time the funds were appropriated, it was understood that they would be obligated over a period of several years.

TEENAGE ALCOHOLISM

Question: Among the most serious problems facing our nation today is the high incidence of teenage drinking and alcohol-related traffic fatalities.

Aren't these problems of such national importance that they should not be left to the uncertainties of funding under a State block grant?

Answer: The Administration's proposal for health services block grants is rooted in the conviction that States, rather than the Federal government, should determine which health services to provide and how to provide them. Federal funds currently awarded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) for prevention of alcohol abuse and alcoholism are proposed for inclusion in the block grant. If the proposal is approved, decisions about expenditures of health services funds for prevention of alcohol-related problems will rest with the States. There is widespread parental and community concern - and active debate in many State legislatures -- about alcohol-related problems among young people. State decisions on the use of health services funds no doubt will reflect such concerns.

Question: Do you believe there should be an ongoing Federal role in the area of Health Promotion and Risk Reduction?

Answer: Yes, there should be an ongoing role for the Federal government in the area of Health Promotion and Risk Reduction. In fact, two years ago the Surgeon General released a landmark report on this subject entitled "Healthy People". The Report expresses an emerging concensus among scientists and health professionals that there are overwhelming reasons why a new strong emphasis on prevention--at all levels of government and by all citizens--is essential. The reasons are that prevention saves lives, improves the quality of life and can save dollars in the long run.

One of the areas of special concern cited in the Report is alcohol abuse. Because of its overuse and general societal acceptance throughout American society, alcohol accounts for a significant share of the nation's medical care cost burden.

Alcohol misuse is a factor in more than 10 percent of all deaths in the U.S., about 200,000 a year. It is associated with half of all traffic deaths, many involving teenagers. Cirrhosis, which ranks among the ten leading causes of death, is largely attributable to alcohol consumption. Alcohol use is also associated with cancer, particularly of the liver, esophagus, and mouth. It has also been found that excessive drinking during pregnancy can produce infants with severe abnormalities, including mental retardation.

The Surgeon General has outlined specific objectives for 1990 in the area of alcohol abuse prevention. These include improving the health status of Americans, reducing risk factors, increasing public and professional awareness of the problems, improving services and providing evaluation of these services.

Question: Would you support the stengthening of efforts to coordinate a health education component between the Department of Health and Human Services and Education?

Answer: The strengthening of the coordination of a health education component between the Departments of Health and Human Services and Education would be of benefit of both agencies. Currently, there is a work group consisting of representatives from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Mental Health (NIMH), and the National Institute on Drug Abuse (NIDA) and the Department of Education's Prevention Divisions which meets monthly to discuss areas of common concern. In the past, NIAAA has developed jointly with the Office of

Education two film series and print materials for use with junior and senior high school students.

Although there are many issues of joint concern to these agencies, there are also areas of specialization and difference. For example, alcohol abuse prevention is a separate important issue which is more concerned with finding new methods of preventing problems of alcohol abuse than developing new educational methods. Although this can include development of some education methods, it is not limited to them. The broad prevention perspective necessary to aid in the development of new alcohol abuse prevention programs could be limited if the educational programs were placed in a generic health education category rather than that of alcohol problems prevention.

The prevention of alcohol abuse problems through education and the rigorous evaluation of these programs are both fairly new concepts and, as such, need to be carefully developed. This is best achieved under the supervision of a scientifically-oriented governmental agency.

Some other distinctions are that NIAAA has worked closely with specialists in both education, alcoholism, and community health fields in order to develop three model alcohol educational programs. These programs take place in a variety of settings including school, community alcoholism programs and universities and utilize a variety of methods. This methodological and environmental flexibility could be lost if these programs were considered strictly as health education programs.

Therefore, although benefit could be derived from a coordination of effort, it is important to remember the distinctions among these agencies.

ALCOHOLISM COMMISSION

Question: Recently, the Committee received a reprogramming request of $500,000 to begin activities of the National Commission on Alcoholism.

What will be the total cost of the Commission?

Answer: Under Public Law 96-180 (enacted January 2, 1980) which established the National Commission on Alcoholism and Other Alcohol-Related Problems $1 million was authorized to be spent over a two year period for the Commission's work. The reprogramming request before you represents the total amount needed in FY 1981 to begin the Commission. The balance of the $1 million authorized under P.L. 96-180 will be required in FY 1982. In addition, P.L. 96-180 authorized the Department of Health and Human Services to provide additional professional and clerical staff, to carry out its functions effectively. This can be done with existing appropriations, staff, and ceilings.

Question: How important is it that the Congress approves funding for the Commission?

Answer: The Congress when it passed P.L. 96-180 establishing the National Commission on Alcoholism and Other Alcohol-Related Problems expressed consensus that alcoholism is the number one health problem that faces this Nation and it was time to bring together a distinguished group of people, both within the government and outside it, to study the problems surrounding alcoholism. We feel it is important in this period of economic constraint that the Congress approve funding for a Commission to review the whole alcoholism effort in this country; not just the efforts of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The Commission will provide very important guidance to the Congress as well as the Executive Branch for years to come in directing our efforts in addressing this vital problem.

NURSING RESCISSIONS AND CUTS FOR 1981 AND 1982

Mr. Andrews: The rescissions and cuts in the 1981 and 1982 budget requests for nurse capitation grants, advanced nurse training and nursing professional traineeships are proposed with the justification that there is adequate training capacity in nursing schools in the country.

Without this support, how does HHS propose to address the severe nursing shortages that are rampant in my state of North Dakota, as well as the rest of the country?

Answer: There are a number of factors beyond the purview of the Federal government which contribute to the nursing shortage such as: low salaries, lack of autonomy, "burnout," lack of opportunity for upward mobility, etc. We are refocusing our limited resources on addressing these issues, particularly with respect to bedside nurses by continuing funding for nursing special projects and nurse practitioners. It is expected that the results of the two year study currently being conducted by the Institute of Medicine will assist the Administration in making decisions on how to best focus future Federal funding for nurse training.

Mr. Andrews: Your proposed elimination and reduction of nursing professional traineeships and advanced nurse training programs seem to imply that this administration feels that advanced or graduate training for nurses is not important. In North Dakota, the University of North Dakota Nursing School was approved for an advanced nurse training grant last summer to set upon the first graduate program in nursing for the state next year. Now, because of these proposed reductions, the school has been warned that the funds will most likely, not be available to begin this graduate program. Although it has a significant amount of state funds, the Nursing School believes it can't begin its graduate program without the Federal share.

Without support for advanced training or nursing professional traineeships, what proposals do you have for "addressing high priority national problems like improving specialty and geographic distribution of health practitioners", which you state is one of your goals in the HHS budget justification book?

Answer: The Department is completing work on a health professions legislative proposal to be submitted to the Congress soon. This proposal will be designed to focus on the most urgent problems related to meeting the Nation's health needs particularly with respect to the difficult problem of geographic maldistribution, the need for personnel in the area of primary care, preventive medicine and health promotion and disease prevention and assistance to the disadvantaged. As part of this new legislative proposal, appropriation authorizations to be proposed for fiscal year 1982 will be consistent with the 1982 President's budget proposal.

MAJOR RIF IN BUREAU OF HEALTH PROFESSIONS

Question: Your budget indicates you propose to reduce the staff in the Bureau of Health Professions from 413 positions in the current fiscal year to 100 positions in 1982. What impact will this RIF have on the need for a stable corps of qualified medical personnel in the United States?

Answer: A reduction of this magnitude will result in the elimination of a substantial number of professional staff positions in the Bureau of Health Professions. The precise number is not known at this time, consequently, we cannot predict the full extent of the impact.

Question: Can the Federal government afford to lose this much experience without seriously affecting the quality of its Health Professions programs?

Answer: Although, a number of experienced employees will be lost, these position reductions generally correspond to program cuts in the 1982 budget request.

Question: Who would manage any new Health Professions Education programs Congress passes in the future?

Answer: If new health professions programs are added by the Congress, the Department will request that the Congress add commensurate staff to carryout these new responsibilities.

"NATIONAL PRIORITY SPECIALTIES"

Question: You talk about refocusing Federal aid for the training of Health Professionals to target support on "National Priority Medical and Non-Physician specialties" where shortages exist.

Aside from focusing on Nurse Training, what other "specialties" do you plan to assist?

Answer: The Administration plans to support graduate programs in public health and health administration, which includes the development of training programs, and support for students, at a 1982 budget request level of $6,000,000. Training support for graduate programs is also included under the Primary Care program in the 1982 budget request at a level of $36,000,000 and $8,000,000 is requested for the establishment and maintenance of family medicine departments. Preventive Medicine Departments and Preventive Medicine Residencies provide for the establishment of departments of preventive medicine and residency and predoctoral training projects at a 1982 budget request level of $3,000,000. Area Health Education Centers will also continue to be funded with the $15,800,000 requested in 1982.

Question: What studies can you cite to back up your statement that the "need for further federal incentives to increase the overall national supply (of Health Professionals) no longer exists?"

Answer: There are many studies that have examined the current flow of health professionals from our educational institutions and have made projections of the future supply of health personnel. In nearly all cases, the studies indicated that the schools either had the capacity to train the aggregate numbers of health professionals needed in the future or that the supply of health professionals in coming years would be more than adequate to meet our aggregate needs; a few even envisioned a surplus in some fields. Among the authors of these studies are the Bureau of Labor Statistics; the Office of Technology Assessment; the Rand Corporation; the Graduate Medical Education National Advisory Committee (GMENAC); the National Academy of Sciences; the Veterans Administration; and the Bureau of Health Professions, Health Resources Administration. In these studies, over a dozen approaches, methods, and models for estimating the future supply and requirements for health professionals have been developed.

In nearly all instances, the approaches to estimating practitioner supplies have considered future enrollments, graduates, attrition, foreign additions, mortality, retirement, and other factors, under a variety of assumptions. The models of future requirements of health professionals have reflected analyses of many factors, including levels and trends in health care utilization, demand or needs, health insurance trends and the effects of insurance on consumption, population size and composition, provider productivity, and provider responses to demand changes. Many of the studies provide forecasts based on alternate assumptions and alternate scenarios. The almost overwhelming conclusion drawn by these studies is that there will be an adequate supply of health professionals in the future, and that the Nation's capacity for training health professionals is in place and that currrent enrollment levels do not need to be increased further.

It is important to remember, however, that no one can know with any real certainty what the future holds for the health professions 20 years in the future. Nevertheless, the expectation of an adequate supply coming from the existing educational pipelines supports the Administration's decision to direct Federal assistance toward more critical health needs than simply increasing the output of our health professional schools.

Question: If we relax in this area now, do you see a day coming when it may be necessary for the Federal government to resume incentives for training Health Professionals? Won't it cost more then?

Answer: While it is true that the cost of educating health professionals is increasing and can be expecting to increase further in future years, the anticipated favorable aggregate national supply/requirements balance through the 1990's indicates that there is likely to be little further need to expand the number of schools or to increase enrollments within existing schools, particularly if health professionals schools remain solvent and maintain roughly the current capacity to train increased numbers of health professionals. In both our health professions analytical and evaluation programs, we will continue to monitor closely changes in the supply of graduates and practitioners, and will develop more precise requirements forecasts. Should major changes occur that would change this anticipated general balance of supply and requirement, new policies can then be recommended with adequate lead time. Should such policy changes be necessary, of course, the capacity to train health professionals will still be in place. Overall, we believe that the capacity of our health professions schools and the number of students currently in the pipeline will provide more than adequate supplies of health practitioners to meet our future needs. Although the ratio of applicants to available places in some professions has edged down somewhat, there are still more qualified applicants to these schools than can be accepted. It is expected that the favorable earnings of health professionals and the other attractions of these occupations will continue to attract large numbers of highly qualified applicants, and that the elimination of Federal incentives will not have the effect of reducing school capacity appreciable, if at all, especially in the face of the continuing demands for admission. Even if small increases or decreases in enrollments were to occur, they would not significantly or irrevocably affect the manpower supplies of the 1990's. For the present, however, our expectation is that aggregate national health professions supply and requirements will be in balance in the 1990's and, therefore, that resources and resultant incentives should be directed to more critical needs.

PUBLIC HEALTH TRAINING

Question: We note your budget proposes to reduce training in the field of Public Health from $17 million under the Continuing Resolution to $6 million in fiscal year 1982.

What is the rationale for this cut?

Answer: The current state of the economy required hard choices in the formulation of the 1982 Federal budget request. The reduction proposed for public health reflects the Administration's decision to more highly target funds available for health professions training to programs with the most potential for addressing health professions training priorities. Currently identified areas of higher priority include the maintenance of efforts to encourage and support production of primary care practitioners and to ensure their distribution in a manner that equalizes access to medical care. Also, activities that will increase the capability of all health practitioners in health promotion and disease prevention will be emphasized.

Question: What will the impact be on the need for trained people to operate Public Health programs in our communities?

Answer: The Administration's position is to continue to provide a somewhat less intensive direct federal presence in the education and training of the necessary public health personnel with greater responsibility placed upon State and local governments to assure themselves of a cadre of well trained personnel. Under the President's budget proposals, we anticipate no serious disruption in the total national capacity to provide basic occupational preparation in public health for work in communities.

Question: Is there any evidence that the private sector -- or even local government -- might pick up some of this cost?

Answer: Total expenditures for public health training have increased while Federal assistance has remained approximately constant. These additional costs have been met through increase tuition, grants from private foundations, and from other private or public sources. We anticipate that this trend will continue in the near future.

NURSING SHORTAGE

Question: President Reagan's message of February 18 indicated that Federal support for Health Professions Education should be refocused on shortage areas "such as nursing."

Why is the Administration's budget proposing to cut Nurse Training support by almost 85% from $83 million to $14.2 million?

Answer: Although the proposed budget reductions for nursing are sizable, we feel they are a necessary part of the Administration's economic recovery policy. These reductions reflect the continuation of the policy of removing financial incentives to increase the aggregate supply of nurses while concentrating the reduced level of resources in those programs, nursing special projects, advance nurse training, and nurse practitioner, which have the potential for alleviating nursing workforce, distribution, retention and utilization problems.

Question: In light of the continued shortage of nurses, shouldn't the federal government continue to support their training?

Answer: There are a number of factors beyond the purview of the Federal government which contribute to this nurse shortage in specific geographic areas and settings such as: low salaries, lack of autonomy, "burnout", lack of opportunity for upward mobility, work pressures resulting from insufficient staff, etc. The Administration takes the position that these problems need to be addressed by the profession and by the hospitals.

MEHARRY MEDICAL SCHOOL

Question: The continued funding of Meharry Medical School in Tennessee has been a source of concern to this subcommittee.

What is the present status of the Meharry problem -- and what are you doing to limit the Federal government's financial commitment to this institution?

Answer: Meharry has developed a five year plan to achieve financial stability. The plan is scheduled for completion by fiscal year 1981. This plan includes a number of actions designed to improve its management, reduce expenditures, and increase income. In its effort to improve management, Meharry has followed most of the recommendations of study groups but has had difficulty in finding adequate resources to fully implement needed reforms. Expenditure reduction over the past several years has been accomplished by cutting back administrative and operational expenses while attempting to support the necessary academic base to maintain accreditation. Income increases over the past few years at Meharry have come largely from Federal grants and contracts, support from the Southern Regional Education Board and raising tuition. Currently the school has initiated a fund-raising campaign which has generated interest from some large foundations such as McArthur and Kellog and has received a large pledge of funding from the Alumni. Meharry is also exploring out-of-State sponsorship of students from New York, Illinois, and other States. While there has been some progress, the delay in implementing necessary reforms, the delay in the development of a new management structure and fiscal problems with the hospital indicate that more time may be required to reach the goals of the five year plan.

Proposed new legislation by the Administration will be introduced to Congress shortly concerning future year commitments to Meharry Medical College and authorization of the Health Professions Financial Distress program. As part of this new legislation, the Administration is proposing that an institution may not receive a financial distress grant exceeding 75% of the previous year's grant.

HEALTH PROFESSIONS CAPITATION

Question: If you rescind all medical school capitation in 1981, how will the schools dependent upon this money find replacement funds in such a short period of time?

Answer: For the past three years the health professions schools have known that capitation would be phased out. The Federal Government can no longer assume the burden for a program that has met its objective of increasing enrollments.

Capitation funds per student received by health professions schools for the past three years are on the chart shown below. As the chart indicates, these funds have been phased down and are now at a per student level where schools can more easily increase tuition and, therefore, not experience a major shock in the loss of capitation funds. Further, State and State-assisted schools are in a much better position than ever to request modest increases in State support to cover the difference received by Federal capitation funds.

Discipline	FY 1978 Amount Per Student	FY 1979 Amount Per Student	FY 1980 Amount Per Student
Medicine	$1,390	$1,087	$639
Osteopathy	1,390	1,087	639
Dentistry	1,390	1,087	639
Vet. Medicine	733	588	422
Optometry	386	310	233
Podiatry	488	392	294
Pharmacy	351	282	212
Public Health	839	809	873

Question: Won't this put the schools -- or at least some of them -- in difficult financial straits, to say the least?

Answer: Health professions schools have known about the reduction and eventual withdrawal of capitation funds. This transition phase has been occurring for the past three years and is now at a per student level where schools can more easily acquire replacement resources and, therefore, not experience a major shock in the loss of capitation funds. Capitation funds represent a relatively small percentage of the overall health profession schools revenue.

Question: Why not continue the on-going reduction of about 20 percent a year to give the schools time to make the adjustment?

Answer: In light of the growing projected supply of most health professionals, the Administration feels it is no longer necessary to continue general subsidies for increasing the enrollment of physicians and other health professionals. We feel the capitation program has been successful in achieving its objectives. Federal funds will be targeted to the most urgent problems facing the health professions.

ALLIED HEALTH

Question: Your budget says Allied Health personnel comprise the link between the patient and the physician or nurse and that these personnel perform key functions in diagnosis (I.E. clinical lab technicians, X-ray technicians, etc.). Your budget would terminate this program.

Can we afford not to fund projects which improve the efficiency of this type personnel?

Answer: Over the past 15 years federal support for allied health training has stimulated a rapid increase in the capacity of the educational system to proved basic occupational training to allied health personnel. This has been accompanied by a notable increase in standards of education and training. This educational establishment is now regarded as of a sufficient size to meet forseeable needs. Some private sector adjustments are seen as still necessary in order to match educational capacity with effective economic demand for personnel. A Federal role for ongoing support of basic operational costs for these programs is not considered to be necessary. Under the current law, appropriations for Allied Health training in recent years have been devoted almost entirely to strengthening and improving the quality of educational programs and not to increasing their numbers or subsidizing their operations. The grants, which are for a 3 year period are made with the assumption that the curriculum improvements will be supported, after that time, by the grantee institutions. We, therefore, anticipate no diminution in quality of these programs. Further improvements are no doubt possible, and if important should be made by the responsible college or university.

Question: Is there a shortage of Allied Health personnel?

Answer: There is generally considered to be no national shortage of Allied Health personnel of a magnitude that requires further Federal intervention. There continues to be localized difficulties in recruitment, and more wide-spread shortage in some specialized operations such as speech pathology, audiology, respiratory therapy and physical therapy. Also, as in the case of most health occupations, highly-competent managers, supervisors, and teachers are difficult to find. However, it is our belief that the private sector is capable of adjusting its training programs to meet these needs.

Question: If you rescind most or all of the $6.7 million in the program in FY 1981, how will the existing training programs cope with such a cutoff?

Answer: The President's FY 1981 budget proposal provides $1.0 million dollars for Allied Health activities, At this level, existing educational project grants can be phased for termination, existing contracts to develop and improve performance standards for personnel can be completed, and MEDIHC programs for placement of personnel can be terminated in an orderly manner. No new grants or contracts will be undertaken. The effects of this on training programs will be small. Effects upon the organizations responsible for developing and applying personnel standards are more difficult to judge.

NURSING RESEARCH

Question: We understand from the Nursing profession that continued research is vital to improved nursing practice in the future. This is the program which led to the development of the nurse practitioner concept, intensive care nurse and other accomplishments.

Why then are you terminating this program in your budget request?

Answer: These programs do not address high priority concerns of the Administration such as improving specialty and geographic distribution of health practitioners and health promotion and disease prevention.

Question: What alternative arrangements are you making with the private sector, including the American Nursing Association, to pick up this work?

Answer: No arrangements are being made with the private sector to pick up the nursing research activities.

ADVANCE NURSE TRAINING

Question: The Nursing profession has placed a very high priority on the need for advanced training because many leadership positions are occupied by persons who are inadequately prepared. Your budget request reduces this program from $12 million to less than $1 million.

Won't a reduction of this magnitude be the end of this effort?

Answer: The request of $1.3 million in fiscal year 1982 will support 10 advanced nurse training projects and is consistent with new legislation to be proposed which calls for targeted assistance to promote national objectives in health professions and nurse training and development.

PHYSICIAN EXTENDERS

Question: The budget requests $5 million for the Physician Extenders program, a reduction of $4.1 million.

Won't reduced Federal support result in a reduction in the numbers of people entering this field?

Answer: Yes, some individual project data shown that when Federal funding is reduced, the number of trainees involved decreases.

Question: Why can't such a program be taken over by the private sector?

Answer: It is difficult to answer this question. The Federal government has been supporting the Physician Assistants movement in terms of assistance to training programs since 1972. During these years, it is estimated that 75 percent or more of the cost of operating these programs came from Federal funding. Currently, there is no good evidence which indicates significant institutionalization of these programs. This may be due to lack of funding availability or that Physician Assistant Training is not being considered the highest local priority as institutions face reductions in other sources of funding.

Question: Could this training be supported under any other federal program?

Answer: There is no other categorical program for support of Physician Assistant training. Other generic authorities such as project grants and contracts for allied health (Section 796) of the Public Health Service Act could be considered. However, no funds have been requested for this program in the fiscal year 1982 budget.

EMERGENCY MEDICAL SERVICE TRAINING

Question: Isn't it important for the nation to have a sufficient number of trained health practitioners in the delivery of emergency medical services? Why are you eliminating funding for this program?

Answer: The Administration recognizes the importance of having a sufficient number of trained emergency medical care personnel, but feels that State and local funding is a more appropriate source of training resources.

INTERNAL MEDICINE & PEDIATRICS

Question: You are proposing a 31% reduction in fiscal year 1981 in training in general internal medicine and General pediatrics -- down from $19.5 million to $13 million.

What is the rationale for this cut? Are these areas no longer priorities?

Answer: The reduction is due to the overall economic condition of the Nation. However, high priority programs such as General Internal Medicine and General Pediatrics continue to be supported due to the need to assure a sufficient supply of primary care providers.

Question: We hear reports that this specialty problem may be turning around -- that medical graduates are going into the Internal Medicine and Pediatrics fields. What is your comment?

Answer: Since the Federal support of primary care programs in recent years, there has been a significant increase of physicians who are classified as primary care practitioners in general internal medicine and general pediatrics.

Question: Why turn off the program if it is finally beginning to pay off?

Answer: The program is continuing despite the economic situation. However, like many other Federal programs, reductions are necessary and an attempt has been made to minimize reductions in this area in view of its high priority objective of maintaining a sufficient supply of primary care practitioners.

Question: If Congress agrees to the rescission, what will happen to the medical students working in these projects?

Answer: In the short-run it is projected that programs would do everything possible to support current trainees through the course of their curricula.

Question: What will happen to the projects?

Answer: The reduction in support for primary care training programs will certainly lead to closure of some programs in the long-run. Also, it is predicted that the program scope and experiences would be curtailed. The depth and breadth of primary care emphases, ambulatory care experiences, etc. may also be reduced.

Question: While you cut back to $13.5 million in fiscal year 1981, you propose to push the program back up to $18 million in fiscal year 1982. Isn't this inconsistent?

Answer: No. In the fiscal year 1982 budget, we combined two primary care training programs, family medicine and general internal medicine and general pediatric activities for a total of $36 million. The comparable amounts requested in fiscal year 1981 were $34 million.

AHECS

Question: The Area Health Education Centers program has been highly successful in attracting primary care practitioners to shortage areas. Your budget reduces the program from $21 million to $15.8 million which will support eight AHEC's. However, we understand that in FY 1982 there will be eleven AHEC's requiring "continuation" support funds totaling over $20 million.

If this is the case, do you propose that three projects be dropped? What are your plans?

Answer: Yes, we do propose three AHEC's be terminated. As soon as we are able, we will carefully review the progress of the existing 11 AHEC's to determine several factors which we will weigh in consideration of which projects will receive future Federal support. These include: identifying those AHEC's which are meeting all of the provisions of the law and which will be able to function without Federal support at the expiration of their sixth year.

SPECIAL PROJECTS--INTERDISCIPLINARY TRAINING

Question: There has been some Congressional support for your special projects authority which supports funding for projects in Geriatrics, Nutrition, Humanistic Medicine and Environmental Health.

In light of indications that we need more -- rather than fewer -- people trained in such disciplines, why do you propose to eliminate funding for this activities?

Answer: These programs were curriculum development projects designed to train health professional trainees across the board. They were not to prepare categorical specialists in these areas.

Question: What arrangements have you made for colleges and universities -- the private sector -- to take on this work after the federal government bows out?--Or do you think the government should simply drop it cold?

Answer: No specific arrangements have been made for the private sector to institutionalize these programs. However, several National conferences have occurred for exchange of instructional materials and ideas developed under these grants. It is hoped that activities of this nature will demonstrate and foster the institutionalization of these activities in the private sector.

Question: What indication do you have that medical schools will continue to support the training projects funded by this program, especially in Geriatrics and Environmental Health?

Answer: We do not have evidence that medical schools will continue these programs. It should be emphasized that these were curriculum development projects which have not had an opportunity to be institutionalized. Much of the instructional materials which have been produced can continue to be used and refined. As previously stated, several National Conferences have occured for exchange of these instructional materials and ideas developed under these grants. It is hoped that this expressed interest will demonstrate and foster the institutionalization of these activities without significant Federal presence.

MONITORING AND SITE VISITS

Questions: Your budget says the $3 million requested for program support activities is for salaries and essential operating cost such as expenses in conducting the national advisory councils and the related peer review process -- activities which protect the federal investment through monitoring and site visits.

Is this amount sufficient to cover all of these expenses -- or won't it do the job?

Answer: The $3 million requested for program support will cover "bare-bones" costs, that is salaries of the 100 positions remaining to administer approximately 18 programs. Costs, such as salaries and travel associated with conducting the National Advisory Councils and the peer review process, could not be supported with this budget request. Other items such as printing of congressional reports, data processing costs to provide information for congressional reports and to develop shortage area designations, and rental of building space and equipment will have to be severely curtailed or eliminated. Additional costs for implementation of new program guidelines, policies and procedures associated with proposed new legislation will have to be deferred.

NURSING CAPITATION

Question: To what extent has the Nursing School Capitation program been successful in stimulating nursing school enrollments?

Answer: The nursing school capitation program has been successful in stimulating nursing school enrollments as well as in developing new schools of nursing.

As reflected in the following chart, total enrollments in participating schools increased from 161,292 in 1973 to a peak of 206,347 in 1978; and increase 191 participating schools and 45,055 full-time student enrollments. In 1979 and 1980, both the number of schools and the number of full-time students enrolled declined somewhat resulting in increased numbers of students enrolling for part-time rather than full-time study.

In the years since 1972 when the first capitation grants were awarded to nursing schools, more than 400 new associate degree and baccalaureate programs in nursing education were developed and participated in the capitation grant programs, of which 256 were Associate Degree programs and 188 were Baccalaureate programs. Numbers of Diploma programs declined from 263 in 1972 to 135 in 1980. Approximately one-third of the new Baccalaureate programs established in recent years are upward mobility programs geared to advance associate degree and diploma graduates to the baccalaureate degree.

For the past three years nursing schools have known that capitation would be phased out. Support for the Capitation Program was predicated upon the need for increased enrollments and improving the quality of nurse education programs. The program has been successful and increased enrollments is no longer the principal objective of the health professions programs.

Enrollments (by type of program) in schools participating in the Nursing Capitation Grant Program 1973-1980

	Total - All Schools		Diploma		Associate Degree		Baccalaureate	
	Number of Schools	Total Enroll-ment	Number of Schools	Total Enroll-ment	Number of Schools	Total Enroll-ment	Number of Schools	Total Enroll-ment
1973.....	890	161,292	209	36,133	408	52,091	273	73,068
1974.....	917	177,351	181	31,723	445	60,310	291	85,318
1975.....	1,050	194,873	171	29,727	485	68,204	322	96,942
1976.....	1,012	194,680	176	30,166	505	71,473	331	93,021
1977.....	1,055	199,615	168	28,519	522	72,630	365	98,466
1978.....	1,081	206,347	165	28,189	545	75,730	371	102,428
1979.....	990	183,374	116	19,030	509	69,534	366	94,810
1980.....	1,075	190,516	135	20,616	554	74,724	386	95,176

HEALTH PLANNING

Question: We note you propose to phase out the federally funded Health Planning Program, presumably cutting off 213 local Health Systems Agencies (HSAs) and 57 State Planning Organizations. A number of HSAs report that they have been able to prevent unnecessary expansion of health facilities and services in their areas. If they're making progress -- why not at least make provision for keeping the good ones?

Answer: We believe that those HSAs and SHPDAs which have shown results in their local communities should be able to attract State and local support. We encourage them to seek local and State funds to continue their activity. We do not believe that Federal funds are required to keep those agencies functioning which have shown progress in addressing the health problems of their area.

Question: Why not establish some criteria for effectiveness and then retain those HSAs and State agencies meeting the criteria?

Answer: Definitive criteria have been established and actual performance of the State and local agencies is measured to ascertain the effectiveness of each agency. Current funding, of course, is based on a formula. As part of the proposed appropriations language, we have proposed that funding to the planning agencies be allowed on a discretionary basis. Once fiscal year 1982 funds are expended, however, it is proposed that such agencies rely solely on State and local support for continuation.

HEALTH PLANNING - STATE AGENCIES

Question: Although you plan a major cutback in the Health Planning Program, there is no reduction proposed for State Health Planning Agencies. Indeed, you propose an increase for these agencies -- from $32 million in 1981 to $45 million in FY 82? What is the reason for this situation?

Answer: Assuming approval of the proposed elimination of the local planning agencies, States will be forced to assume additional responsibilities and functions currently being performed by the local agencies. The additional funds will support these expanded State efforts, assistance in effecting the transition at the local levels, and in preparing for the phase out of Federal funding for State planning.

Question: Why can't State agencies take a proportionate cutback -- like everyone else?

Answer: Proportionate reductions to State planning agencies would eliminate any potential for an orderly phase out of Federal support for health planning. Sufficient time is needed to effect an orderly transition and to secure alternate sources of funding for planning activities. The State agencies may use some of their funds to help selected localities in an orderly phase-out of Federal support.

HEALTH PLANNING - PROGRAM SUPPORT

Question: Mr Secretary, all Departments and Agencies of the Federal Government are being forced to cut back programs and staff in the interests of reducing Government spending. Yet, it appears that you have not requested much of a rescission for Health Planning, Program Support in fiscal 1981. Your request was for a cut of only $215,000. For the time remaining in the current fiscal year, please tell us how much you still can rescind and what the effect will be. Keep in mind: We are looking for the largest rescission possible.

Answer: The proposed rescission amount of $215,000 is the maximum savings which can be realized in the balance of 1981 from beginning to effect a 1981 position reduction of 100 positions.

STATE INVOLVEMENT IN HEALTH EDUCATION

Question: How much are the States spending now for health education programs?

Answer: In FY 1979, 29 state health agencies reporting programs in health education spent a total of $8.4 million. In FY 1980, 35 states reporting programs in health education spent a total of $8.3 million. These figures -- based on data collected for the National Public Health Program Reporting System by the Association of State and Territorial Health Officials -- must be qualified, however, since the dollar amounts only show up in the NPHPRS figures where the state considers health education to be a separate program. Other funds may go to health education activities -- under a hypertension or alcohol abuse control program, for instance -- and not appear in the NPHPRS data.

There are no data available to show what the states are spending for school health education, from either the Department of Health and Human Services, the Department of Education, or the private sector Association for the Advancement of Health Education.

Question: What State matching requirements exist for current Federally-funded health education programs?

Answer: In general, Federal-funded health education programs do not have State matching requirements. The Health Education/Risk Reduction Grant program at the Centers for Disease Control provides funds to States to conduct a state-wide health education program with no matching required. This grant program also provides funds for local projects through the States with no matching requirement. Formula grants for the National Institute on Drug Abuse and the National Institute on Alcoholism and Alcohol Abuse fund single state agencies and there are no matching requirements. Project grant funds for Community Mental Health Centers include consultation and education activities are funded for eight (8) years with a declining Federal share from 90% down to 20% before complete phase out.

Question: Can the States assume more responsibility for a greater share of the funding?

Answer: In the past, health education programs have found it difficult to compete with the highly visible health service programs and legislatively mandated environmental health programs. With the advent of block grant funding more flexibility will be given the States for considering the funding of health education programs. It is anticipated that as the States identify the need for and resultant benefit of health education programs they will consider such programs as a priority for funding.

Question: If the States are given more discretion for deciding the exact array of health education programs, what emphasis do you expect would be placed on programs such as hypertension and family planning?

Answer: We can only assume that States would make their decision based on certain identifiable criteria. Example of such criteria would include: the prevalence of the problem at hand, the effectiveness of interventions to produce a desired change, and the existence of certain special target groups within a particular area. Based on such criteria, every State would make its own individual assessment of the problems within its boundaries. It is, of course, likely that programs such as high blood pressure and smoking would be among the high priorities for all States, but there are a number of others which might also fall into this category including accident prevention, family planning, alcohol and drug abuse control, physical fitness and exercise and stress control.

CONSOLIDATION OF HEALTH EDUCATION PROGRAMS

There are numerous programs with the Department of Health and Human Services providing health education services.

Question: Instead of all these various agencies putting money into programs for health education, why not set up a separate Bureau to administer them in a more coordinated, cost-effective manner?

Answer: Because health education is such an integral component of all of the Public Health Service programs, it would be impossible to consolidate all health education activities into a single unit. For example, the National Heart, Lung and Blood Institute (NHLBI) has a program mandate to provide information in response to public demand about high blood pressure, heart disease, and other problems related to the mission of the Institute. It would not only be counter to the statutory mandates, it would also be programmatically inefficient to prohibit the NHLBI from providing informational and educational materials to the public on high blood pressure and related matters. The same issues apply to programs such as Maternal and Child Health in HSA, Food and Nutrition in FDA, Immunization and Sexually Transmissible Diseases in both NIH and CDC, and so forth.

Question: What savings would result from the States having to deal with only one Federal Bureau instead of numerous agencies?

Answer: This is a question which can only be answered through careful review of States own programmatic, accounting, and reporting processes. From the point of view of the Federal Government, most Federal agencies' health education efforts do not require extensive reporting by States. The bulk of these health education efforts are related to provision of informational materials and technical assistance by the individual agency with relevant program expertise. Hence, States might well find it to be relatively more inefficient to have to deal with a central agency which was one step removed from program expertise and operations. Though, theoretically a single site for health education activities would improve access to services and information, in fact practicalities would result in the reverse situation.

As an example, consider the information and education program for alcohol related service programs, the various State agencies would go directly to their counterpart Federal agency for information on program content related to health education. In this way health education is handled more efficiently than by attempting to provide it through some relatively less informed 3rd party.

Cross-cutting issues do require a mechanism for program operation and coordination, and there are organizations within the PHS to handle such matters.

HEALTH STATISTICS COLLECTION

The National Center for Health Statistics (NCHS) provides for the collection, analysis, and publication of national health statistics through the operation of a number of national systems.

Question: During the recent past, what percentage of the surveys have been conducted directly? Through the Bureau of the Census? Through private contractors?

Answer: The Surveys conducted by the Center are usually not performed exclusively by one source. We have found it best to use the resources and knowledge most appropriate to the task. Therefore, more often than not, portions of each survey will be done by Census or contractor coupled with direct participation of the Center staff. Of the eight major surveys being conducted by the Center, 38% are conducted directly by Center personnel, 12% by the Bureau of the Census, and 50% by private contractors.

Question: How does the Center insure comparability and reliability of the various health statistics it gathers or uses from other agencies?

Answer: The Center specifies the requirements of the data, and compiles, regardless of whether it collects the data itself or arranges to have the Census Bureau or private contractors serve as its data collector. When the data are collected by contractors, the data requirements are included in the contract specifications, and the Center staff closely monitors the contractor and the data collection operations to assure the data requirements are satisfied. In this manner, the Center assures data comparability and data quality for the health statistics that are gathered by other agencies for the Center's use. If another agency collects health data, but not exclusively for the Center's use, the Census usually does not have the authority to assure data comparability and data quality. In these instances, the Center tries informally to reach understandings with other agencies by agreeing on minimum data sets and by standardizing the forms and definitions. If, despite these precautions, the data compiled by other agencies do not meet the Center's standards for data comparability and reliability, the Center will either appropriately qualify these statistics in its reports or reject the statistics as being unsuitable for publication in its reports.

Question: What efforts have you made to determine if savings are possible by combining your work with the statistical gathering efforts of such agencies as the Bureau of Labor Statistics, the Bureau of the Census, the Occupational Safety and Health Administration, and the Health Care Financing Administration?

Answer: A primary goal of the Public Health Service's data collection and processing plan is to insure that data collected by the various programs is done in a coordinated and efficient manner. It is the responsibility of the PHS Health Statistics Coordinating Committee, chaired by the Director of NCHS, to establish the methods and procedures by which this goal may be obtained and then to monitor the implementation of data collection and processing systems.

The philosophy is that the resources and capabilities of one agency should not be duplicated by another when the data needs of both can be met through a single data system. It is the responsibility of the Health Data Advisory Committee, co-chaired by the Deputy Assistant Secretary for Health Research, Statistics, and Technology, to assure coordination across the Department. As a result of the philosophy and the functioning of the Coordinating Committees, we now have several projects underway, jointly financed by multiple agencies, designed to meet their data needs through a coordinated data collection mechanism. For example, the Health Care Financing Administration is providing funds to the National Center for Health Statistics to supplement the National Medical Care Utilization and Expenditure Survey in order to obtain detailed information on Medicare and Medicaid beneficiaries, thus providing HCFA with very useful program data at substantial savings; the NCHS contracts with the Bureau of the Census to interview survey respondents so that the expertise and resources of the Census field staff will not have to be duplicated; when producing the annual report submitted to the Congress on the health of the U.S. population, Health, U.S., the NCHS includes data provided by many Federal agencies including HCFA, VA, and the Bureau of Labor Statistics; the NCHS uses the expertise of the Center for Disease Control to process and analyze blood and urine samples drawn in the National Health and Nutrition Examination Survey; and the NCHS maintains a formal reimbursable work program through which other agencies can provide resources to NCHS to supplement existing large scale national surveys to obtain information needed for specific program purposes, thus negating the necessity of each of these programs to mount individual national survey mechanisms.

INTERNATIONAL HEALTH

Question: What activities of the Office of International Health are to be abandoned as part of the proposed reduction for Fiscal 1982?

Answer: The only activity being abandoned insofar as it has involved personnel hired by this Department is the conduct of special studies and analyses for the Agency for International Development. In the past, these studies have included country background studies on AID-assisted countries, papers on health issues that are relevant to U.S. health programs in developing countries, and health strategy statements and planning documents for AID assisted countries.

Question: Is it possible the termination and close-out costs could be higher? What is your estimate--and what do you base it upon?

Answer: If the President's budgets for Fiscal Years 1981 and 1982 are enacted as proposed, we would not anticipate additional termination costs over the amounts currently proposed.

PUBLIC HEALTH SERVICE REGIONAL MANAGEMENT

An 80 percent reduction in Public Health Service regional personnel is proposed for fiscal 1981, reducing the average number of personnel in each region from 20 to 2 or 3 persons.

Question: Is this reduction to be accomplished through dismissal of personnel or through attrition?

Answer: The proposed 80 percent reduction of personnel in the Public Health Service regional management account is for fiscal 1982. To accomplish this reduction personnel will have to be dismissed.

Question: In the dismissal of personnel, is a lag time provided to allow states to set up their own management for block grant programs.

Answer: The block grant proposal does not provide any lag time to allow states to set up their own management. As of October 1, 1981, the Public Health Service will grant the funds directly to the states and federal personnel are to be off the Government roles as of October 31, 1981.

Question: What will be the responsibility of regional personnel following enactment of block grants?

Answer: By reducing the average number of personnel in the regional management account from approximately 11 to 2 or 3 persons in each region the responsibilities will be reduced to that of overall direction and a liaison function.

Question: Is there actually to be a savings realized, or is this primarily a shift from federal funding to state funding of Public Health Service program management?

Answer: We anticipate that the block grant mechanism will effect real savings through the elimination of duplicative administrative costs and overlapping program functions. In anticipation of such savings the total amount of block grant funding for fiscal 1982 represents a reduction of 25 percent below fiscal 1981 total categorial funding for those programs to be incorporated into the block grant.

Question: Could any of these activities be phased down, or phased out prior to Fiscal 1982, and at what savings?

Answer: The activities conducted in cooperation with AID are being phased down now, inasmuch as several of the AID funded positions are vacant and will not be filled, since they will be abolished on October 1, 1981. This does not result in a savings to this department, however, since the funds are from prior year AID appropriations and will no doubt be used by AID for other purposes.

COST OF STATISTICAL PUBLICATIONS

Question: How much do you spend on publication and distribution of statistical information?

Answer: The budgeted amounts to be spent on publication and distribution of statistical information by NCHS is $1,535,000 in FY-1981 and an estimated $1,595,000 in FY-1982.

Question: How much of that expenditure is recovered through sales and subscriptions?

Answer: NCHS does not directly sell publications. Data tapes are sold, however, and it is estimated that $36,000 will be recovered by the Center in FY-1981 and $37,000 in FY-1982 from these sales.

Both NCHS statistical publications and data tapes are also sold through the National Technical Information Service and the Government Printing Office although these funds are not recovered by NCHS. These sales amount to an estimated $50,000 annually.

TERMINATION SUPPLEMENTAL

Question: I note you are requesting $120.7 million in a Fiscal Year 1981 supplemental to cover termination and close-out costs related to the program and staffing changes you intend to make. What is the authority for this supplemental -- or are you asking us to authorize and appropriate at the same time?

Answer: All activities to be funded by the PHS Termination Expenses account are authorized under the PHS Act and Title V of the United States Code.

Question: What is your estimate based upon? How solid is it?

Answer: The total amount requested for the PHS Termination Expenses account was derived by computing anticipated costs related to the specific program reductions or terminations proposed in the President's revised budgets for Fiscal Years 1981 and 1982. Total estimated termination costs are based on individual computations of such items as severance pay and lump sum annual leave for employees separated from employment; residual overhead cost requirements for eliminated operations; various costs associated with closure of the PHS Hospitals and Clinics system; and one-month salary costs for employees to be separated on October 31, 1981. We believe that our request can be supported as a fair estimate of our requirements.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Increased financial support of HMOs by private sources, as well as the development of privately funded HMOs in metropolitan areas, has led the Administration to propose the elimination of the HMO grant program. A rescission request of $28 million would greatly reduce HMO development activities in fiscal 1981, and grants for these activities would be eliminated in fiscal 1982.

Question: Will a complete cutoff of Federal dollars for new starts, as well as expansions, have a dampening effect on private sponsorship?

Answer: OHMO does not believe that the phase-out of the grant program will have a dampening effect on private sector involvement in HMO development. As a result of eight years of Federal support, the feasibility of the HMO concept has been proven and further development can be accomplished through private sector capital. There are about 120 HMOs currently being developed by private non-federal groups--significantly more than the number currently being supported by the Federal government through the grant program. In recent years increasing amounts of private capital have become available for HMO development. This is largely due to the success of the Federal grant program in developing a competitive atmosphere in a number of different marketplaces. OHMO believes that this private capital will continue to be available for the development of financially viable HMOs. While the Federal government will be ending its role as a financier for HMO development, the OHMO will continue to support the development of HMOs. This will be done through its promotional activities, the training of current and new HMO management, and the provision of technical assistance to developing HMOs. In addition, OHMO will continue its regulatory activities--qualification and compliance--to assure the public and employers of the financial viability and quality of care provided by qualified HMOs.

Question: In stimulating private funding of HMOs, what approaches to provide both tax incentives to HMO developers and easier access to Federal loan guarantees have been explored?

Answer: The questions of providing tax incentives to HMO developers and easier access to Federal loan guarantees are being investigated by OHMO and discussed with the HMO Industry Council, which is made up of key business and labor people. OHMO has no specific proposals on either issue at this time.

Question: How many of the HMOs that have received Federal Assistance are now entirely supported by the private sector?

Answer: As of December 31, 1980, a total of 27 qualified HMOs that have received Federal Assistance are now entirely supported by the private sector. Fifteen of these received grant support only--no Federal loans or loan guarantees. There are 12 HMOs that have received loans that are repaying principal as scheduled (nine received grants and loans). In FY 1981, OHMO expects that 12 additional HMOs will begin making principal payments on their loans.

Question: How many of the Federally assisted Health Maintenance Organizations have a good chance of continuing operations without Federal financial assistance?

As of December 31, 1980, there are 118 Federally qualified HMOs and of those 41 are operational without any Federal loan monies at all, and could continue to operate without any further Federal monies. Of the 77 HMOs that are operating with Federal loans, 12 have already reached a point of financial health (break even) and are no longer dependent on Federal monies. The remaining 65 HMOs are still dependent on Federal monies (Federal loans), and it would only be speculation as to how many of those would be able to reach breakeven if they no longer have Federal loan monies.

In terms of the HMO development activities as of December 31, 1980, there were 42 organizations with feasibility grants and 31 with planning grants. OHMO anticipates that approximately 15 of these will be awarded initial development grant funds during FY 1981. The remaining organizations in the feasibility or planning stages will have to secure private financing to continue development.

It is impossible to project with any certainty the likelihood of these organizations obtaining private funding to continue development. Our best estimate is that possibly 10 to 15 will be able to secure private funds to continue development.

Question: Will or should the Federal government, in your opinion, assume any responsibility to protect the members of HMOs that may fail as a result of discontinued development grants?

Answer: OHMO does not believe that the Federal government has any such responsibility. Grant funds are given to carry out activities to develop an HMO. They may not be used to support the operational costs of an organization nor to cover any part of the costs of providing health care. Most of these HMOs do not have any enrollees because they are preoperational entities.

HEALTH MAINTENANCE LOAN GUARANTEE FUND

The Administration has proposed a large reduction in management training and technical assistance personnel (from 205 to 130) for fiscal 1982. At the same time, the budget indicates default losses of $45.2 million in the HMO loan guarantee program during 1981 and 1982, or about 33 percent of the $135 million in loans outstanding at the end of 1980.

Question: Is the management training and technical assistance program so ineffective that it is not worth continuing at its present level in fiscal 1982? Or will phasing down this assistance indirectly result in even greater defaults to the loan fund in fiscal 1982?

Answer: Prior to answering the questions, OHMO would like to make two points. First, OHMO has an FY 1981 appropriated level of 205 positions in total. Positions are not appropriated specifically for the Management Training and Technical Assistance activity. Second, OHMO currently projects $30.4 million in loan defaults in FY 1981 and 1982. These projections, if accurate and combined with $15.7 million in defaults through FY 1980, would total $46.1 million by the end of FY 1982 or approximately 15 percent of the $325 million in projected commitments for loans and loan guarantees through FY 1982.

OHMO believes that significant progress has been made in implementing its Technical Assistance authority and its Management Training program. Technical assistance is provided to both grantees and qualified HMOs primarily through the use of teams of individuals with expertise in HMO operations. Organizations experiencing major problems in several operational areas are offered technical assistance to help them overcome their difficulties. A consolidated technical assistance contract has been awarded and is designed to provide this assistance to approximately 24 grantees and qualified HMOs each year. Technical assistance is also provided in specific areas of HMO operations by individual specialists. Five major contracts and OHMO staff are used to make available individuals with technical expertise in the areas of finance and marketing, quality assurance, health care delivery systems, management information systems and management. Of the 21 plans assisted to date under the consolidated Technical Assistance Contract: 12 have benefited from this effort; 7 are still receiving assistance; and 2 did not appear to utilize the assistance to their advantage.

The Management Training Program is made up of two separate activities. First is the National HMO Management Fellowship Program which is designed to help meet the demand for HMO management talent. Two classes, totaling 62 Fellows, were selected for the 8 month intensive classroom and field training program. Upon completion of the Fellowship Program the Fellows will be prepared to assume key management responsibilities in HMOs. The effectiveness of the Fellows Program cannot be measured until at least FY 1983 when the first class of Fellows completes its training and the Fellows assume their positions in the industry for a period of 6 months to a year.

The second portion of the training program is the HMO Management Seminar Series. This program is designed to expand and improve the management skills of current HMO managers through 2- or 3-day seminars dealing with specific HMO activities. OHMO believes the Management Seminar Series has been very effective. This is a subjective assessment, however, as it is difficult to attribute specific improvements in individual skills directly to improvements in the HMOs' performance at this time. Success can only be measured at a later date when we see how many of the developing and qualified HMOs reach breakeven.

The proposed reduction of $500,000 for Management Training and Technical Assistance in FY 1982 is tied to the proposed phase-out of the grant program and in no way reflects ineffective Management Training and Technical Assistance efforts. With the grant program ending in FY 1981, the demand by grantees for Technical Assistance will greatly diminish (approximately 20 ID grantees may need some assistance during FY 1982 and 1983). The individuals or teams of experts will be working with qualified HMOs. This phase-out may result in slower growth of the HMO industry as future development will be solely dependent on private capital. The demand for new HMO managers therefore will be spread out over a longer period. OHMO plans to select its next class of Fellows from individuals already working in the industry who will be sponsored by operational HMOs. Under this arrangement, the government and the operating HMOs will share the cost, thereby contributing to a reduced need for funds in fiscal year 1982.

OHMO does not see where the reduction in Management Training and Technical Assistance will contribute to additional loan defaults in FY 1982. OHMO believes there are sufficient funds to provide technical assistance to qualified HMOs; that the Fellows program will provide the needed managers; and that the 20 Seminars projected for FY 1982 will all serve to strengthen the industry's management. All these activities should help to keep the number of defaults within the current projections.

SMOKING AND HEALTH PROGRAM

Question: What measurable effects has the smoking and health program had in deterring smoking and assisting those that smoke to quit?

Answer: Cigarette smoking is the leading preventable single cause of early death and premature illness in the United States. The Office on Smoking and Health is the successor agency to the National Clearinghouse for Smoking and Health which was established in 1965 to respond to this problem. Since 1965 there has been a Federal focal point dealing with smoking and health, carrying out the following functions:

1. Collecting, organizing and disseminating the world literature on smoking and health.

2. Analyzing all types of scientific information for the purpose of establishing and maintaining Federal policies on smoking.

3. Serving as a scientific and public information resource to individuals, institutions, and organizations throughout the U.S. and worldwide.

4. Designing, testing and disseminating models for preventing the uptake of smoking and encouraging smoking cessation, for use at the national, State, and local levels.

5. Serving as a central point of contact at the Federal level for stimulating the involvement and cooperation of private, voluntary health agencies, professional organizations, and the entire public health community.

Over the 16 year history of this Federal concern over smoking and health, surveys have shown a direct and dramatic correlation between national attention on smoking and the proportion of the population who smoke. While State and local governments have assumed greater responsibility for smoking and health activities, they have been assisted in this by the leadership, scientific and technical information, technical assistance and encouragement provided by the Federal focal point.

In the February 13, 1981 issue of Science, Professor K. E. Warner of the School of Public Health, University of Michigan, estimated that per capita cigarette consumption in the United States would have exceeded its 1979 level by more than a third in the absence of an antismoking campaign.

Measurable downturns in per capita cigarette consumption can attributed to the national antismoking efforts. The first of these occurred after the publication of the 1964 Surgeon General's Report, and the second took place during the late 1960s when the government and voluntary agencies were guaranteed access to major amounts of television time under the FCC Fairness Doctrine. The third began in the mid-1970s and has accelerated in the years since 1978.

Since 1978, when the Federal smoking effort was given renewed emphasis, substantial progress has been made as indicated by the following:

- Per capita cigarette consumption has continued to decline and is now at the lowest level since 1957.
- In 1980, 36.7% of men and 28.9% of women smoked cigarettes, compared to 53% and 32% in 1964.
- There have been changes in the choice of cigarettes by smokers; from 1978 to 1979 the proportion of smokers choosing cigarettes of less than 15 mg tar increased from 29.0% to 33.7% (a 13% increase in just one year).
- Over the past two years of OSH program operation, national surveys reveal that the number of former smokers increased by 1.8 million adults. Further, of that number, there were 1.1 million women vs. .7 million men. It was during this period that the OSH placed increased emphasis on informing women about the specific risks they faced if they smoked and published its 1980 Report on The Health Consequences of Smoking for Women.
- Cigarette smoking among adolescent boys is estimated to be lower today than at any time since the 1920s and 1930s. Although in 1979 a higher proportion of adolescent girls smoked than boys, the prevalence of smoking among young girls now appears to be declining.

Question: Do you have any evidence to suggest the relative success of educating adolescents and adults against smoking as opposed to educating young children?

Answer: No health education effort can ever neglect the need to teach children at very early ages the relationship between what they do and how their body functions. More and more this kind of teaching is going on in our schools, with apparently increasing effectiveness.

In the case of cigarette smoking, teaching health education in the elementary schools must be accompanied by programs addressed to children, adolescents, and adults. Research has consistently shown that children and adolescents smoking behavior is closely related to the smoking behavior of their parents, older siblings and friends. Therefore, any program concerned with educating children about the health hazards of smoking must also address the behavior of those individuals who have a direct and indirect influence on the behavior of the child.

Surveys have shown that we have been successful in educating young children as well as older adults. In 1980, 36.7% of men and 28.9% of women smoked cigarettes compared to 53% and 32% in 1964. Over the past two years, 1.8 million adults became former smokers. Cigarette smoking among adolescent boys is estimated to be lower today than at any time since the 1920s and 1930s. While in 1979 a higher proportion of adolescent girls smoked than boys, the prevalence of smoking among young girls now appears to be declining.

Question: If this program is primarily informational, why is it not located in the Department of Education?

Answer: The smoking and health program is not restricted to information, but is a multi-faceted approach to address one of this country's major public health problems. This program is responsible for:

1. Collecting, organizing, and disseminating the world literature on smoking and health.

2. Analyzing all types of scientific information for the purpose of establishing and maintaining Federal policies on smoking.

3. Serving as a scientific and public information resource to individuals, institutions, and organizations throughout the U. S. and worldwide.

4. Designing, testing, and disseminating models for preventing the uptake of smoking and encouraging smoking cessation for use at the national, State, and local levels.

5. Serving as a central point of contact at the Federal level for stimulating the involvement and cooperation of private, voluntary health agencies, professional organizations, and the entire public health community.

6. Assessing and coordinating the direction of the research activities of multiple Public Health Service agencies and collaborating with other Federal departments involved with aspects of tobacco and cigarette issues.

A primary role in teaching young children about cigarette smoking belongs to the schools. In the case of older children, adolescents, and adults, smoking and health education must be carried on in other ways, as for example through the health care system, through voluntary health agencies and through the mass media. This can be accomplished only by a public health agency working closely with the medical and behavioral research fields. Cigarette smoking affects a minimum of 15 diseases which are the responsibility of 10 different agencies of the Public Health Service.

Question: It is my understanding that you are consolidating the Smoking and Health Program with the Health Promotion Program in Fiscal 1982. What impact will this have on existing smoking and health activities?

Answer: The Public Health Service is in the process of developing a Comprehensive Health Promotion Plan which includes activities of Smoking and Health. It is important to note that smoking is the single most preventable health problem and is a major focus of the efforts in disease prevention and health promotion. The 1982 budget reflects a redefinition of the Federal effort in health promotion and smoking and health. As a result there will be an impact on smoking and health activities. A number of options are being considered to determine the best way to utilize funds requested in 1982. The scope of some smoking activities will be decreased including the availability of public and technical information. Efforts will be made to generate more private sector involvement in these areas.

Question: Will the reduction of 12 employees be a result of attrition, or will personnel have to be dismissed? What impact will the staff reduction have on smoking and health programs?

Answer: At this point it is not possible to determine what portion of the position reduction will be accomplished through attrition. The remaining employees would be subject to a reduction in force action. A staff decrease like a dollar decrease will necessitate some streamlining of activities in the areas of public and technical information, as well as the maintenance of a smoking and health bibliography and data collection.

PHYSICAL FITNESS AND SPORTS

The Physical Fitness and Sports Program has requested a 27% increase in funding over Fiscal 1981 for Fiscal 1982, in addition to 4 new positions.

Question. What evidence can you supply to verify that the Physical Fitness and Sports Program is having an effect on the health of the American population?

Answer. We don't have any direct evidence that the program is improving the health of the American people, but we can make a logical inference to that effect. There are any number of studies showing that regular exercise is beneficial to health and effective against some of the leading risk factors for heart disease, such as obesity and high blood pressure. There also are studies documenting the tremendous increase in exercise and sports participation. Add these facts together and the conclusion seems inescapable.

PUBLIC HEALTH EMERGENCY RESPONSE FUND

Question: The fiscal 1981 request provides $20,000,000 for the establishment of a Public Health Emergency Response Fund which will provide resources necessary for PHS to respond to assistance requests promptly and without unnecessary delay. What guidelines have you developed for use of this fund?

Answer: To address the administrative issues surrounding the use of the Response Fund, PHS is currently developing plans for financial and personnel management activities to be used once the Secretary has designated an emergency as a threat to the public health. In addition, the PHS Incident Specific Planning Project is underway to improve PHS emergency planning and response. The objective of this effort has been to develop a system of guides to identify the PHS response activities to a full range of possible disasters such as energy and material shortages, natural disasters, and technological hazards. The guides will identify major health issues created by the disaster, a chronological listing of possible response activities, identification of lead PHS coordinating agency and participating agencies, and a cross-reference to supporting operational plans.

Question: Some emergencies are longterm in nature--such as Love Canal and Mt. St. Helen's--requiring evaluations and monitoring over an unknown period of time. How will the funding for these emergencies be handled?

Answer: The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (P.L. 95-510 "Superfund") provides authorization and resources for health assessments resulting from environmental hazards. The 1982 request for this activity in the Environmental Protection Agency is $.2 billion.

Question: Will health effects studies from disasters such as Mt. St. Helen's be funded?

Answer: Assistance for long-term monitoring and evaluations would not be provided by the Response Fund. The fund would serve as a contingency resource to be activated only for major health emergencies which pose an immediate threat to the public health.

In the case of the Mt. St. Helen's emergency, the Centers for Disease Control had the lead responsibility for the Department in assessing possible health problems, especially possible respiratory problems, associated with the volcanic ash. The effort was funded by a Supplemental of $600,000 in FY 1980. Any subsequent monitoring or evaluation study would not be supported by the Response Fund.

Question: What will be the relationship between this fund and the Centers for Disease Control's environmental hazards program?

Answer: The Response Fund would enable PHS to assist a local community or State government in responding to their initial health concerns during a public health emergency that exceeds the local ability to act quickly and effectively. These emergencies occur in various forms such as environmental catastrophies, disease outbreaks or epidemics, or natural disasters. Short of declaring an official disaster, there is no funding mechanism in place for providing needed assistance to determine or control adverse health effects due to large-scale emergencies.

On the other hand, the environmental hazards program in CDC is designed to improve state and national expertise in preventing illness due to environmental hazards. Program resources support technical assistance to States on quality standards for solid waste disposal, sewage disposal, water supply and housing. Other activities include epidemic investigations, emergency aid on a limited scale, laboratory development, training, professional and public information and program evaluations.

Question: How will this program co-ordinate activities with the Environmental Protection Agency?

Answer: In many instances, the nature of the emergency (an unidentified disease agent, natural disaster, or environmental accident), and the availability of local resources will define the role of Federal assistance and response activities. Since different Federal agencies have overall lead responsibility with regard to particular aspects of any emergency, the National Response Team, with regional counterparts, was established to provide overall coordination. The Regional Response Teams, composed of representatives from various agencies, are responsible for on-site coordination of an environmental emergency response. Assisting local authorities, the Regional Response Team will develop recommendations for immediate actions and will determine the local capacity of the community to fulfill the response requirements. PHS activities to assess possible adverse health effects and EPA activities to identify and monitor environmental conditions will be coordinated by the Regional Response Team. Similar interagency coordination would occur under the Federal Emergency Management Agency, which would assume lead responsibility upon a Presidential declaration of a national emergency.

Question: What assurances will States have of available funds at the time an emergency occurs, and at who's discretion will an emergency be funded? (The Secretary's)?

Answer: This request is based on prior experience. Over the past three years the PHS has spent about $64 million or approximately $20 million per year responding to six major health emergencies including Three Mile Island, Mt. St. Helen's, Cuban/Haitian refugees, Legionnaires Disease, Michigan PBB exposure and Love Canal. No year availability of Emergency Response Funds would eliminate the lapsing of funds at the end of the fiscal year if there are few emergencies. It would also eliminate the need to request new budget authority for the following year.

Section 311 of the Public Health Service Act authorizes the Secretary, at the request of the appropriate State or local authority, to extend temporary assistance in meeting health emergencies.

HEALTH SERVICES RESEARCH

Question: What programs are being affected by the Administration's proposed $1.336 million rescission in Health Services Research?

Answer: The mission of the National Center for Health Services Research (NCHSR) is to undertake and support research, demonstrations, and evaluations on problems in the organization, delivery, and financing of health care services; to serve as the focal point for coordination of health services research within the Public Health Service; and to disseminate the findings of health services research to policy and decisionmakers in the public and private sectors. The essential functions of intramural and extramural research, dissemination and coordination will continue at the reduced level, but there will be fewer new grants for research studies, fewer dissemination conferences and publications, and less extensive intramural research.

Question: How closely does the Center for Health Services Research work with the Office for Policy Research in formulating Departmental policy? Could the two offices be consolidated?

Answer: The National Center for Health Services Research (NCHSR) does not directly participate in the formulation of Departmental policy. The research which NCHSR conducts and supports examines questions which are relevant to the formulation of Federal, State and local health policy and the establishment and operation of health programs. NCHSR communicates the results of this research to policymakers and program managers, but it does not directly share in the establishment of policies. NCHSR maintains communication with the Office of the Assistant Secretary for Planning and Evaluation, which, among its broader responsibilities advises the Secretary on policy issues. There is regular exchange of information on proposed projects and sharing of the results of research. The functions of the two offices are quite distinct, and a consolidation would not be appropriate or productive.

IMPACT OF HEALTH SERVICES RESEARCH ON HEALTH CARE POLICIES

Question: What research programs sponsored by the National Center for Health Services Research have led to changes in health care policies that have saved Federal health outlays? Estimate the amount of savings involved.

Answer: Since NCHSR is a research organization, it is not directly involved in formulating, choosing or recommending specific policies. Its task is to provide information and the results of experience to data on policy actions in areas that it has studied and whether these policy decisions have led to outlay savings. The results of research often reveal the opportunity to follow a course of action which could yield outlay savings, but other factors must also be taken into account by those making the decisions. The information provided by NCHSR is generally one source of knowledge used by policymakers to assist them in their choices among policy options.

A review of the experience of NCHSR on several issues on which it has sponsored research provides some evidence of financial implications of its findings.

- NCHSR played a key role in the development of four publications which review the research on issues related to health care cost containment:
    - Health: A Victim or Cause of Inflation. Edited by Michael Zubkoff, 1976.
    - Controlling the Cost of Health Care, May 1977.
    - Hospital Cost Containment, Selected Notes for Future Policy, Edited by Michael Zubkoff, Ira E. Raskin, and Ruth S. Hanft, 1978.
    - Controlling Health Care Costs: An Evaluation of Strategies. Ira E. Raskin, Rosanna M. Coffey, and Pamela J. Farley, 1980.
- Research supported by NCHSR has examined significant aspects of cost containment issues. The following are examples:
    - Effects of the payment mechanism on the health care delivery system.
    - Changes in the costs of treatment of selected illnesses.
    - A study of the utilization experience of the Federal Employee Health Benefits program.
    - Impact of the economic stabilization program on hospitals.
    - The productivity of health manpower.
    - Financing of catastrophically expensive illness.
    - Determinants of physicians' fees, and physician fee inflation.
- An important intramural study under way is examining hospital costs and utilization. This study is securing data on a sample of hospitals in the U.S. to explain variations in levels and patterns of hospital utilization--both of which are important determinants of hospital costs.

The research explores the implications of variations in hospital use for costs as well as for access and the quality of care. The findings are expected to provide new information for developing strategies directed toward altering utilization levels and patterns, and for predicting hospital behavior in response to specific cost containment policies. The studies focus on how and why hospitals differ in such characteristics as case mix, lengths of stay and ancillary services used for specific illnesses, occupancy rates, capitalization, and manpower utilization.

- More effective training, reimbursement and utilization of nurse practitioners and physician assistants could lead to economies, NCHSR studies have shown. For example, physician assistants trained in diagnostic radiology were able, in one study, to save 34 percent of the radiologist's time--almost 90 days in a typical work year.

- Research supported by the NCHSR is reducing costs in the clinical laboratory. The late Dr. Pete Neurath, of Tufts-New England Medical Center, Boston, designed, under NCHSR support, a prototype computerized differential white blood cell counter with high potential for reducing the per test cost. Innovations made during its development have provided advanced technological information for commercial counters now being marketed. More accurate and faster than the manual method, the computerized scanning microscope reads cell size, index of refraction, and color, and identifies their cell type, shape, and counts. The test is one of the most frequently performed in the clinical laboratory.

- Results of a study supported by the NCHSR and carried out at Duke University Medical Center show that the heart attack victims who experience no complications during the first four days of illness can be considered for discharge on the seventh day of hospitalization--eight to ten days less than the average length of stay for the illness. This finding has the potential of reducing expenditures for hospital care by more than $360 million annually.

- The NCHSR has pioneered in the development of clinical data banks. These data banks provide a new approach to assessing clinical decisions for individual patients and for evaluating the value of specific diagnostic and therapeutic technologies. The value of these data banks is now widely acknowledged. For example, the ARAMIS data bank at Stanford University has been used to assess the value of renal biopsy. As a result of this analysis, it is now evident that this procedure provides no information beyond that already available from standard kidney function tests in patients with a particular connective tissue disease. This finding has not only eliminated the risks associated with this procedure, but has also reduced the costs of care--approximately $500 for every patient.

- Screening for cervical cancer by testing at four year intervals instead of annually could result in significant cost savings nationwide and only a slight increase in the numbers of deaths due to the disease. That is the suggestion of a study on the costs and benefits of the Pap Smear test by Stuart Schweitzer and Bryan Luce of the University of Southern California, with support from the National Center for Health Services Research. Results indicate that annual Pap Smear screening for cervical cancer costs about $76,000 per incidence detected, compared to about $18,000 when screening is done at four year intervals.

- A study of the effects of the use of the certificate-of-need procedure to limit capital expenditures by hospitals was conducted in Massachusetts under a grant from NCHSR. The study examined the amount and kinds of capital investment made in Massachusetts' voluntary hospital industry from 1967 to 1976, a period which spanned five years before and five years after introduction of certificate-of-need (CON) regulations in that State.

  Over the period 1972 to 1976, 25 percent of all projects submitted by sample hospitals to CON were either denied or modified significantly through review. By 1976 and beyond, as the regulatory process matured, CON review reduced project scale and cost by as much as two-thirds of that originally proposed.

- The use of a computerized patient admission scheduling system developed under an NCHSR grant was estimated to yield a saving of about $700,000 in its first year of operation at one hospital studied in the Washington, D.C. area.

UTILIZATION OF HEALTH SERVICES RESEARCH

Question: How does the National Center for Health Services Research implement its recommendations?

Answer: The research which the National Center for Health Services Research conducts and supports aims to provide information which can assist policymakers, program administrators, health care providers and the public. As a research agency, NCHSR does not make policy recommendations but provides information which becomes one of the considerations in the policy-making process.

NCHSR undertakes a dissemination program designed to bring to the attention of the decision-makers the results of its research. Often these findings enable these persons to take immediate action to put findings into effect. More rapid dissemination through publications has occurred in the last two years. Research syntheses are being prepared to pull together research results in specific program areas, like HMOs, for use by policymakers and the public. For example, NCHSR is completing a workbook which will enable hospital administrators who are contemplating the installation of a computer system to examine the variety of designs available in relation to his or her needs. Thus the work may be put to immediate use.

RESEARCH INITIATIVES

Question: What new initiatives are planned for Fiscal 1982?

Answer: In 1982, we will be restructuring priorities into five areas as follows: medical technology assessment, health information systems, prevention and promotion, health care economics (insurance, costs, and expenditures), delivery of health services (organizational arrangements, competition).

COOPERATIVE HEALTH STATISTICS SYSTEM

The Cooperative Health Statistics System (CHSS) was established for the purpose of producing comparable and uniform health information and to assure appropriate access to such data. Last year the Center proposed a reduction in funding for Cooperative Health Statistics, and placed greater emphasis on State agency capability and coordination.

Question: How has State agency capability responded in the last year?

Answer: The response to emphasis on State agency capability has been remarkable. The Governors and legislatures of 34 States have designated State CHSS Agencies to coordinate health statistics in individual States and adhere to guidelines for further State agency development. Many States have made considerable progress in areas other than direct data collection--particularly in data analysis and dissemination, and in planning a coordinated system. Thirteen States, under developmental contracts, are improving capabilities over the range of State agency functions. Response on the part of the States to our contract solicitation, and the 34 States that have designated a State CHSS Agency, indicate the commitment and interest on the part of States in this program.

Question: Has the funding reduction caused any specific problems for the State agencies?

Answer: During the past year many States have been in a difficult transition from Federally funded data collection (manpower and facilities) systems to partial State funding. As a result the overall capabilities, in terms of direct data collection and trained staff retained, has diminished in many States.

These severe funding reductions are further limiting the viability of State efforts to coordinate and improve statistical activities at the State level, and remove much of the incentive for States to designate focal agencies for the coordination of statistical activities. The primary impact of these cuts will fall in future years, when the lack of coordination will result in more duplication, increased respondent burden, and diminishing utility of data.

Question: How many of the State agencies now receive contract support for the various components of the system?

Answer: In FY-1980, 44 State agencies received contract funds for CHSS vital statistics; 30 for health manpower; 36 for health facilities; and 13 State agencies received funds for State Agency Development projects. Thirty-six States had previously been funded in health manpower, but due to budget reductions in FY-1980 six States were not funded in that component. The further budget reduction in 1981 has resulted in total elimination of CHSS Health Manpower and Health Facilities and continuance of only the vital statistics component in the 44 State agencies.

HEALTH SERVICES STATISTICS

The National Center for Health Statistics is designed to collect and provide needed information to government, the health industry, and consumers of health services.

Question: What part does each state presently play in determining the priorities in terms of what information is needed?

Answer: The Cooperative Health Statistics System has since its inception been dedicated to the concept of a Federal-State-local partnership in health statistics. At all these governmental levels, the needs and concerns of the health industry and private consumers were taken into account as well as in developing minimum data sets and common reporting systems. This effort has been augmented by meeting with the AAVRHS. One mechanism that was effective in some States was the development of a consortium where all interested data users and providers in the State formed a non-profit corporation to determine common data needs, efficient collection methods, and useful data analysis. As State statistical agencies were formally identified in compliance with P.L. 95-623, some of these consortia serve to provide data provider/user input to decisionmaking regarding statistical systems.

More recently the final report of the Panel to Evaluate the Cooperative Health Statistics System recommended that:

> "The National Committee on Vital and Health Statistics (NCVHS) consider major policy issues of the Cooperative Health Statistics System (CHSS) on a regular basis, and that the composition of the NCVHS membership reflect knowledge of and experience with the substantive and technical aspects of the CHSS."
>
> "The NCHS convene a meeting of the Directors of State CHSS agencies and other participants in the CHSS at least once a year to review operational concerns and development of the program."
>
> "The NCHS also seek and use the advice of many related State and local health program leaders, public and private."

To the extent permitted by staffing and funding levels, NCHS has been following these recommendations.

Question: Do all states presently have their own health statistics and research agencies?

Answer: A significant effort has been made in recent years to develop State health statistical agencies and expand capabilities to provide statistical services for priority programs. Jointly with the States, guidelines have been developed which identify six functions for these agencies: (1) coordination to assure timeliness and quality of data, (2) data collection, (3) data processing, (4) analysis, (5) user services, and (6) research and development. Capabilities are being developed at the State level to allow for data provider/data user input, to reduce reporting burdens and duplicative systems, to maximize data application, to meet multiple user needs, to preserve confidentiality of data, and to share costs for support of statistical system.

There are today only a few States that can report significant success in terms of this broadly defined, significant effort. Examples of States with notable achievements would include Hawaii, Maine, Michigan, Minnesota, Missouri, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and Wisconsin.

There are, however, statistical capabilities in all States operating from very minimal levels to, in rare instances, a full range of services. Vital statistics data (natality and mortality, for example) are produced in all States and Territories. In 44 registration areas the data are prepared on computer tapes which meet standards of timeliness and quality and are used by multiple agencies including the Department of Health and Human Services. The Department and the States share in the support, in setting standards, and in monitoring the quality of the data. In 35 of the States a State health statistical agency has been formally identified to pursue the objectives outlined above. Most of these have acted to develop advisory committees (or related structures), have begun to review available statistical systems, and provide some services to users.

In general, the States have been very supportive of the need for these agencies and capabilities. An example of this is provided by the continuance of health manpower statistics and inpatient facility inventories (but with some limitation of scope, frequency, etc.) by most of the 36 States previously supported in part by the Federal Government under the auspices of the Cooperative Health Statistics System.

In summary at this point in time there exist some structure in all States, some sharing of statistical information in all States, and a general understanding of the need for and a commitment to the development and maintenance of health statistical agencies which could meet the full range of defined functions and services. To build upon this base States must seek and obtain support to maintain and expand their existing capabilities and significant efforts must continue regarding the development of agreed upon standards and the sharing of technical information, services, and data.

Question: In light of charging states with allocation responsibilities for many health and social service programs, why are you phasing out the State Agency Development program?

Answer: Over the past several years, the Cooperative Health Statistics System has actively supported State Agency Development through direct financial support, technical assistance, training, guidelines, and development of definitions and standards. While primary responsibility is being shifted to the States for financial support, the National Center for Health Statistics will continue to facilitate State Agency Development by providing national leadership in definitions and guidelines, and by promoting communication and technical assistance between States and the national level through the designated State statistical agencies. Thus far 35 State statistical agencies have been designated as called for in Section 306(e) of the Public Health Service Act.

Question: What will be your relationship with the State Agencies in determining State needs for the proposed block grants?

Answer: The function of the Department will be to assist States to develop and maintain a capability to determine and estimate the needs for health services, to monitor the availability of health services, and to evaluate specific health program efforts. At minimum this requires the Department to work jointly with the States to (1) develop statistical standards and guidelines; (2) to share technical expertise; and (3) to monitor statistical efforts to assure efficiency, accuracy, timeliness, and relevance of data. Proper use of and accountability for block grant funds and programs will be dependent on the adequacy of this shared responsibility between the Department and the States.

Question: What lower priority statistical information is being dispensed with, and at what savings?

Answer: We are not proposing to dispense with any of our national health data systems. However, because of rising costs and reduced budgets we are examining each data system to determine what savings can be gained by reducing the survey level or collecting the data less frequently. Beginning in fiscal year 1982 we will be decreasing the sample size of the Hospital Discharge Survey thus requiring data to be collected over a two-year period, rather than the current one-year period, for publication of statistics of the use of our nation's hospitals. Similarly we will be conducting the Master Facility Inventory, which produces a census of hospitals and nursing homes in the country, over a two-year rather than one-year period. We will also be reducing our efforts in the analysis of data from the Medical Care Utilization and Expenditures Survey. These changes will save an estimated $1.3 million in FY 1982 and offset increased costs in our other program activities.

Question: To what degree could money be saved and statistical integrity still maintained by collecting data at less frequent intervals?

Answer: We believe that there can be savings by modifying the frequency of surveys and we are currently examining each of the NCHS data systems to estimate these potential savings. Factors which must be considered in this analysis include the uses to which the data is put and the resultant timeliness, accuracy, precision, and detail required. Also to be considered are administrative aspects such as scheduling of work flow and possible "start-up" costs if surveys are shut down and then started again in subsequent years.

We do not yet have the answers to all these questions nor do we have estimates of projected savings that would result from implementation of a comprehensive plan of revised survey frequencies. However, we are moving toward modifying the frequency of some or all of the NCHS data systems and in fact in FY 1982 we are beginning by changing the data collection cycle in our Hospital Discharge Survey and the Master Facility Inventory from one year to two years and the (NAMCS) from annually to every three years.

Question: What new initiatives are being planned for Fiscal 1982?

Answer: The National Center for Health Statistics does not plan any new initiatives in 1982.

HEALTH CARE TECHNOLOGY

The purpose of the National Center for Health Care Technology (NCHCT) is to assure the most appropriate use of health care technologies (in terms of patient out-come and cost-effectiveness) by conducting assessment activities and providing advise on the appropriate uses of new and existing technologies.

Question: How are your priorities developed?

Answer: The National Center for Health Care Technology (NCHCT or Center) with the assistance of the National Council on Health Care Technology (Council), is responsible for setting the priorities for health care technology assessment, and for final selection of the topics for assessment. The Council has developed criteria that are applied in selecting and setting the priorities for assessment (see attached publication, "Procedures, Priorities and Policy for Assessment of Health Care Technology", prepared by the Council). These criteria include the actual or potential risks and benefits to patients associated with the use of the technology; the actual or potential cost of the technology; the actual or potential rate of its use; the stage of development of the technology; and, the potential for abuse, such as overuse and inappropriate use.

A preliminary review of an identified technology is undertaken to define the important issues it poses and to compare it to other related technologies. The results of this review are utilized to set the priority for a particular technology in the overall technology assessment program. The Council determined that the priority assigned to a particular criterion might vary, depending upon the stage of development of the technology. Accordingly, three categories of development were chosen -- "emerging", "new", and "established" technologies -- and for each a different ordering of priorities was made.

Consistent with its policy of openness and broad participation, the Center consults in the priority-setting and selection processes with a wide variety of parties and groups in both the public and private sectors. Recommendations regarding candidate topics for technology assessment are made by a number of individuals or groups, including the Council, the Department of Health and Human Services (DHHS) Technology Coordinating Committee, Federal agencies outside the DHHS, the Office of the Assistant Secretary for Health, the Office of the Secretary, the Congress, medical and other professional health-related groups in the private sector, and the public. With the large number of potential topics for assessment, setting specific priorities is essential.

Question: Under your proposal to consolidate the Office of Health Care Technology with the Office of Health Services Research, what lower priority studies would be dispensed with?

Answer: The Department has submitted a proposal to consolidate the National Center for Health Care Technology and the National Center for Health Services Research. The new entity, to be renamed the National Center for Health Services Research and Health Care Technology, will place emphasis on studies pertaining to medical technology assessment, health information systems, prevention and promotion, health care economics (insurance, costs, and expenditures), delivery of health services (organizational arrangements, competition). The proposed budget for the new entity is $20 million. Overall, the budget represents a decrease in funding, which in turn will mean a de-emphasis of certain current research activities. Areas that are expected to be de-emphasized include studies relating to the supply, distribution, and costs of health manpower, financing of long-term care, economic studies relating for example, to the cost of facilities and equipment, emergency medical services, and planning and regulation. These studies are currently being undertaken in other Public Health Service agencies.

Question: How has the Center's program had the most impact over the past year in preventing overuse of technological advances, and in avoiding the use of poorly-developed technological devices?

Answer: While the National Center for Health Care Technology (NCHCT) has not singularly been responsible for preventing overuse of technological advances or avoiding the use of poorly-developed technological advances, it has provided information for and has played a coordinating role in departmental policy of decisionmaking on whether or not the use of particular technologies should be promoted. To date, the Center's greatest and most immediate impact has been through its provision of scientific and medical advice to the Health Care Financing Administration (HCFA) on Medicare coverage issues. These issues are questions raised by HCFA regarding the safety and efficacy of particular medical items, procedures, or services and the appropriateness of their reimbursement Medicare. HCFA uses this advice in determining coverage policy for the particular technology and in developing reimbursement instructions for Medicare carriers and fiscal intermediaries.

In evaluating Medicare coverage issues the Center ensures that practicing physicians, clinicians in the research community, other investigators from a wide range of biomedical and behavioral disciplines, representatives of the health industry, members of the general public, and others participate actively in the assessment process at appropriate stages. The Center also obtains information and advice from one or more of the agencies represented on the Department of Health and Human Services (DHHS or Department) Technology Coordinating Committee (TCC), as appropriate, and from representatives of extra-governmental groups, such as medical specialty societies and manufacturing organizations.

Through its evaluations and recommendations on Medicare coverage issues, the Center may impact on both the quality and cost of health care. For example, if HCFA implements an NCHCT recommendation and extends coverage to an item or procedure which has been demonstrated to be safe and effective, the quality of care is enhanced. If such an item or procedure replaces a more complex and costly procedure, money is saved. Conversely, if the NCHCT finds that a treatment or service is unproven, based upon an evaluation of the data, the overall quality of care is improved for Medicare beneficiaries and money is saved when HCFA determines not to reimburse. It should be pointed out that the Center plans to publish (at the invitation of the Editor) in the Journal of the American Medical Association for the information of the practicing community and the public, the substance of the evaluations it provides HCFA. Consistent with its policy of openness, the basis for any particular recommendation also will be made public by the Center. Accordingly, the results of the Center's evaluations can also be used by private third-party payors in their decision-making on reimbursement policy.

It should be pointed out that, as it becomes available at various points in the assessment process, the NCHCT disseminates for timely use in the practice setting evaluative and other pertinent information about particular technologies. For example, as a derivative of its current assessment activities pertaining to ESRD, the Center had an integral role in the development of the Surgeon General's advisory statement, "Treatment of Water for Use in Dialysis; Artificial Kidney Treatments" that was published by the Public Health Service in June 1980.

Question: Please highlight the Center's recommendations to HCFA on Medicare coverage issues and associated savings during the last year.

Answer: The Medicare coverage issues on which the NCHCT has provided advice to HCFA span the full spectrum of medical practice, from obsolete practices to new, or in certain cases, investigative technologies. In fiscal year 1980, the Center provided HCFA with evaluations and recommendations on a total of 38 coverage issues. Of these, the Center recommended non-reimbursement for 15 technologies. To date, HCFA has issued national coverage instructions on approximately half of the 38 technologies on which the NCHCT provided evaluations and recommendations in fiscal year 1980.

Two groups of researchers and economists, one at Harvard University (directed by Dr. Howard Frazier, Director, Center for the Analysis of Health Practices) and the other at UCLA (directed by Dr. S. O. Schweitzer, Director, Program in Health Planning and Policy Analysis), have developed methodologies to estimate the cost impacts of Medicare coverage decisions, and have applied these methodologies in estimating the impact on costs of several NCHCT recommendations that certain technologies not be reimbursed under Medicare. The findings of the Harvard study show that the NCHCT recommendations on Medicare coverage issues can result in significant cost savings to the Federal government and society as a whole.

In their study, the Harvard group focused on four new medical technologies which the NCHCT had recommended not be covered under Medicare: endothelial cell photography (specular micoscopy of the cornea, providing high-magnification photographs of the cornel endothelium, the layer of cells along the inner surface of the cornea); dialysis for schizophrenia (clinical management of schizophrenic patients through dialysis of the blood); hypothermia for cancer (treatment of malignant disease by elevating the temperature of the entire or selected areas of the body); and, radial keratotomy for myopia (microsurgery to remold the cornea of the eye to correct a refractive error, near-sightedness). As reflected in the following chart, the Harvard group estimated that for the Medicare program alone, non-reimbursement of these therapies could save $88 million to $959 million over a ten-year period. They also projected that if the NCHCT's recommendations for non-reimbursement of these technologies were adopted throughout the health care system, $471 million to $2.554 billion could be saved within that same time frame.

Question: In light of your new proposals, will any of the staff of the present Office of Health Care Technology be shifted to HCFA?

Answer: This question refers to the National Center for Health Care Technology (NCHCT or Center), which is responsible for performing technology assessments and related research and for providing, for the Public Health Service (PHS), medical and scientific advice to the Health Care Financing Administration (HCFA) on Medicare coverage issues. The Department of Health and Human Services (DHHS or Department) intends to abolish the NCHCT and assimilate its technology assessment and research functions into a new entity, the National Center for Health Services Research and Health Care Technology (NCHSRHCT), to be established through consolidation of the National Center for Health Services Research (NCHSR) and the NCHCT. With respect to the function of advising HCFA on Medicare coverage issues, the DHHS is considering currently the pros and cons of the following options: (1) transferring this function to HCFA, (2) establishing in the immediate office of the Assistant Secretary for Health a small staff to provide the advice needed by HCFA, (3) delegating the function to the Director of the National Institutes of Health (NIH), or (4) transferring responsibility for the function to the NCHSRHCT.

Whatever decision is reached regarding the appropriate organizational locus for processing and providing advice on Medicare coverage issues, it is anticipated that the responsible unit would be comprised, at a minimum, of six professional and three support staff. The assumption underlying this estimate is that the Department will not alter significantly the process which the NCHCT has established and followed in handling Medicare coverage issues. These staff have the medical and technical expertise that is essential for the effective coordinating of Medicare coverage issues, and the strong experience based upon which program continuity can be maintained. The Department is considering reassigning several persons from the NCHCT to whatever entity is finally selected to carry out this important function.

SUMMARY OF TEN-YEAR SAVINGS EXPECTED FROM CURRENT DECISIONS NOT TO REIMBURSE

(MILLIONS OF DOLLARS*)

	Medicare Population (Age 65)			U.S. Population (All Ages)		
	Low Estimate	Middle Estimate	High Estimate	Low Estimate	Middle Estimate	High Estimate
Endothelia Cell Photography	45	105	350	55	130	450
Dialysis for Schizophrenia	8	29	150	39	146	750
Hypothermia for Cancer	25	163	440	42	272	734
Radial Keratotomy for Myopia**	10	15	19	335	477	620
TOTAL	88	312	959	471	1025	2554

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* Present Value, 1980 Dollars

** Two sets of diffusion assumptions were examined; the results are shown as High and Low Estimates. The Middle Estimate is the arithmetic mean of the two.

Question: Please comment on the Center's relationship to other Department components.

Answer: Within the Department of Health and Human Services (DHHS or Department), the National Center for Health Care Technology (NCHCT or Center) is the focal point for coordinating departmental activities pertaining to health care technologies and their assessment. The principal mechanism through which the Center achieves this coordination is the DHHS Technology Coordinating Committee (TCC). The TCC, which includes representation from all agencies of the Public Health Service (PHS), the Health Care Financing Administration (HCFA), and a number of agencies outside the DHHS, has been meeting regularly since the Center began operations early in 1979. The Mandate for the TCC, which instituted formally the role of the TCC in the Department, was signed by former Secretary Harris in November 1980. Thus, for the first time, the DHHS, and indeed the Executive Branch, has a formal coordinating mechanism and forum for identifying and discussing departmental issues associated with health care technologies; information exchange and interagency cooperation on health care technology matters; and, joint action on relevant issues.

The TCC also serves as an internal departmental advisory body to the NCHCT Director on matters pertaining to NCHCT programs and activities. Agencies represented on the TCC also assist and collaborate with the NCHCT in planning and conducting health care technology assessments within the scope of their authority and mandates, to the extent that resources are available. The TCC also makes recommendations to the NCHCT Director on such matters as:

1. means of improving coordination among DHHS components, other Federal agencies, and State and local agencies in activities pertaining to health care technology;

2. the dissemination of information pertaining to assessments of health care technologies;

3. the implementation of recommendations derived from assessments of health care technologies;

4. the identification and selection of technologies for assessment;

5. the provision of advice to the Health Care Financing Administration (HCFA) on Medicare coverage issues; and,

6. the identification of newly emerging technologies.

The TCC is chaired by the Director of the NCHCT and includes representatives of the Food and Drug Administration (FDA); HCFA; Centers for Disease Control (CDC); National Institutes of Health (NIH); Health Services Administration (HSA); Health Resources Administration (HRA); Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); National Center for Health Services Research (NCHSR); and, the National Center for Health Statistics (NCHS). It also includes liaison representation from the Office of the Secretary (OS), the Office of the General Counsel ()GC) and Inspector General (OIG) in OS, the Office of the Assistant Secretary for Health (OASH), and the Office of Health Research, Statistics, and Technology (OHRST). Other Federal offices, agencies, and departments with interests in health care technology also are requested; they include, for example, the congressional Office of Technology Assessment (OTA); the Office of Science and Technology Policy (OSTP) in the Executive Office of the President; the Veterans Administration; the National Institute of Handicapped Research (NIHR) in the Department of Education (DE); and the Department of Energy (DOE). The National Aeronautics and Space Administration (NASA) and the National Bureau of Standards (NBS) also will be invited to participate in the TCC.

In addition to their representation on the TCC, certain Federal agencies and programs also have ex-officio representation on the National Council on Health Care Technology (Council). The Council fulfills a number of advisory functions in conjunction with the programs of the NCHCT. The heads of the NIH, CDC, HCFA, FDA, and OSTP are ex-officio members of the Council, as are the Chief Medical Officer of the VA, the Assistant Secretary for Health and Environment of the Department of Defense (DOD), the Chairman of the National Professional Standards Review Council, and the Chairman of the National Council on Health Planning and Development.

In discharging its responsibilities the NCHCT draws upon the strengths and expertise of other agencies of the Public Health Service (PHS), and, when indicated, upon other Federal agencies as well. When appropriate, the Center complements or cosponsors health care technology assessments conducted by other Federal agencies. In its evaluations of the appropriateness of Medicare coverage for particular health care technologies, in response to HCFA requests for PHS guidance on coverage policy, the NCHCT relies heavily on the medical and scientific advice which is provided to it by other PHS agencies such as the NIH, FDA, CDC, and ADAMHA. With regard to the Medicare coverage determinations process, the PHS and HCFA have negotiated successfully a Memorandum of Understanding (MOA) which delineates, formalizes, and strengthens the relationship between the two agencies in this activity. Another MOU, between the NIH/Office for Medical Applications of Research (OMAR) and the OHRST/NCHCT, is being developed to delineate and clarify the role functions of these agencies as they pertain to health care technology assessment.

Question: How will health care technology information be disseminated to the practitioner under the new proposal?

Answer: A major objective of the National Center for Health Services Research and Health Care Technology (Center) will be to insure that the evaluative information which it generates about health care technologies is disseminated widely and expeditiously, and in a useful form. The Center will use a variety of mechanisms to disseminate such information, e.g., reports to the professional and general press and media outlets; direct publication through Federal informational services, such as those of the National Library of Medicine and other components of the National Institutes of Health (NIH), and of the Food and Drug Administration (FDA); medical, scientific, and other professional organizations; and, meetings and conferences held by the Center and various professional, governmental, and other groups.

After technology assessments and Center-sponsored conferences are completed the Center will disseminate information in two stages. Within one month after a conference or a significant phase of an assessment is completed, a summary highlighting the major findings and recommendations will be published. The second stage will involve the release of a full technical report on the subject technology or edited proceedings of the conferences, or both. Monographs and "Fact Sheets" on particular technologies will be developed and published for use by practitioners and other interested parties. These publications will provide background or "state-of-the-art" information on the subject technology, identifying the key issues related to its development and potential or actual use.

PHYSICAL FITNESS AND SPORTS

In Fiscal 1980, financial support from the private sector and other Federal agencies for projects proposed, promoted and co-sponsored by the President's Council on Physical Fitness accounted to more than $29 million.

Question. In light of the large outside support of this program, why can't it be totally assumed by the private sector?

Answer. The outside financial support would quickly dry up and disappear without the efforts of the President's Council and its staff. Nearly all of the outside support is the result of approaches made to the private sector by the staff. The private sector finds these cooperative ventures attractive largely because of the involvement of the President's Council and because the projects bear a seal of approval from the Council.

Question. Why can't the educational responsibilities of this program be transferred to the Department of Education?

Answer. The physical fitness and sports program is not simply a school program. It affects individuals, communities, the workplace, parks, recreation agencies, retirement homes, commercial health clubs, sports organizations, etc. Neither the old U.S. Office of Education of the new Department of Education ever devoted any significant amount of effort or resources to the support of physical education.

Question. Would it be appropriate for this office to promote private support of the National Youth Sports Program, which has been targeted for elimination from the Community Services Administration in Fiscal 1981?

Answer. It should be pointed out that there has always been a significant amount of private support for the NYSP. The participating colleges donate all of the facilities and some of the equipment and staff. Several large firms have provided financial support, as have some States and cities. If the $6 million Federal contribution is eliminated, some of the colleges, principally large State institutions, will continue their programs. After all, several of them had such programs before the Federal Government was involved.

HEALTH INITIATIVES

Question: To what extent are the funds of Health Initiatives programs directed at.

- -- Information Services
- -- State and Local Services
- -- Research
- -- Educational Services

Answer: The health initiatives programs include health promotion, smoking and health and physical fitness. A major effort in these areas is to provide information to the public and, in some cases, the scientific community. There is no provision of services as such at the state and local level, however, our public awareness efforts are coordinated with state and local organizations and a very effective working relationship is maintained. No funds are specifically used for research in these areas. Our educational efforts are directly related to informing the public about the health consequences and/or benefits of individual behavior.

Question: Are there any reasons that the Office of the Assistant Secretary for Health cannot function as manager of health initiative funds, and reimburse the Department of Education for developing and administering health education activities, and reimbursing NIH for related health research?

Answer: As mentioned above, our major thrust in these areas is information dissemination, and our health education is in the form of technical assistance to other Federal agencies and some private sector organizations. It is felt that the Public Health Service is the most appropriate organizational locus for these functions and a reimbursable arrangement would not be beneficial. The National Institutes of Health request and receive funding for biomedical health research.

Question: What other agencies and departments are involved in similar health efforts, and how has the Health Initiative Office coordinated activities with them? Are you satisfied with the co-efforts as they now exist?

Answer: We believe that the coordinative efforts in school health currently being done between the Department of Education and the Department of Health and Human Services should continue. It is our belief that the DHHS can significantly contribute to the development and evaluation of school health curricula through the health expertise available in PHS. The working relationships as they now exist are satisfactory.

OFFICE OF HEALTH RESEARCH, STATISTICS, AND TECHNOLOGY

Question: What impact will the 20% reduction in staff, proposed for fiscal 1981, have on the Office of Health Research, Statistics and Technology programs?

Answer: The staff reduction proposed by the Administration is for fiscal year 1982. This proposed reduction in staff is consistent with the Administration's proposals for fiscal year 1982 reductions in funding for the National Centers of Health Services Research, Health Statistics and Health Care Technology, the programs that are directed through this office.

Question: Will you have to dismiss personnel, or do you expect to make the reduction through attrition?

Answer: At this point it is not possible to determine what portion of the position reduction will be accomplished through attrition. The remaining employees would be subject to a reduction in force action.

HEALTH PROMOTION ACTIVITIES

In 1982, the Health Promotion activities of the Office of the Assistant Secretary for Health are cut by nearly 60% from the Carter Budget. This program gave particular emphasis to informing the public of the dangers of smoking.

Question: Since Health Promotion is a key concern of the new Administration, why is this program being cut by nearly 60%?

Answer: Health promotion activities are carried out throughout the Public Health Service agencies. The activities within the Office of the Assistant Secretary for Health concentrate on setting national priorities, determining the most effective approaches, and establishing objectives within the priorities. A coordinating function is served for all PHS efforts. As a result of budget constraints even the high priority areas were reduced and the 1982 budget reflects a redefination of the Federal effort in health promotion and smoking and health.

Question: What evidence is there that the return on Federal spending is greater in health research as opposed to health promotion activities.

Answer: It is not a matter of return on the Federal investment but rather the need to provide stability in the research community. When the Fiscal Year 1982 budget was revised a particular concern was the maintenance of a sound base in biomedical research. Health promotion activities will continue to be a high priority effort of the Department.

LONG-TERM CARE

Presently, the Health Care Financing Administration estimates that long-term care costs represent roughly 40% of overall Medicaid costs. Long-term care is the largest and fastest-growing component of Medicaid, and to some extent this reflects the fact that the Government does not seem to have a comprehensive approach to the long-term care problem.

Question: What initiatives is the Administration planning in this area?

Answer: We believe that integrated approaches to long-term care are best developed at the State and local level, based on knowledge of local needs and conditions.

Our National Long-Term Care Demonstration program (the "channeling initiative") is assisting States and local areas in experimenting with alternative approaches.

Our Medicaid cap proposal will remove current restrictions which prevent States from covering many alternatives to institutional care under Medicaid. This greater freedom will allow States to develop their own integrated, comprehensive approach to providing long-term care.

LONG-TERM CARE — TITLE XXI

Senators Packwood and Bradley have reintroduced their legislation to create a new Title XXI of the Social Security Act. This bill would authorize a series of 10 State-wide demonstration projects over a 6 or 8 year period, to set up alternatives to long term care, emphasizing programs which keep people out of institutional settings as much as possible. Under Secretary of HHS David Swoap testified at his confirmation hearing that he saw much merit to this approach.

Question: Does the Administration intend to support this kind of comprehensive approach to long-term care? Why?

Answer: We support the concept of integrated approaches to long-term care which emphasize alternatives to nursing home care.

We believe, however, that comprehensive approaches which expand noninstitutional services while still maintaining effective control of overall costs can best be developed at the State level in the context of a capped Federal financial commitment.

Therefore, under our Medicaid cap proposal, we would remove current restrictions which prevent States from covering many alternatives to institutional care under Medicaid. This greater freedom will allow States to develop their own integrated approaches to providing long-term care, while assuring that overall cost containment remains a primary objective.

SURVEY AND CERTIFICATION

Mr. Secretary, one of your first actions after taking office was to withdraw the Carter Administration's nursing home regulations, which many people believed to be too costly and burdensome. It is very important, however, to make sure that our elderly receive quality medical care.

Your FY '82 budget, however, calls for a reduction in certification reviews of Medicare and Medicaid providers.

Question: How can HCFA assure that providers meet minimum standards if certification reviews are reduced?

Answer: Under current law, all skilled nursing facilities must be surveyed annually. This limits our flexibility to direct more resources toward problem facilities. The legislative proposal will permit us to develop survey plans which eliminate unnecessary surveys of facilities known to consistently maintain certification standards.

In order to set priorities for survey activity, we are identifying the key standards which are critical to facility operations. Using the Medicare/Medicaid Management Automated Certification System (MMACS), we will identify those key standards most often unmet. Subsequently, we intend to survey facilities based on the identification process where facility data is reviewed in relation to the key standards. This review strategy, supported by a program of sample surveys of facilities under reduced surveillance, should provide reasonable assurances that the good facilities will maintain high standards.

Question: Under present law and regulations, what authority does HCFA have to force substandard facilities to come up to minimum quality standards?

Answer: Until the Omnibus Reconciliation Act of 1980, the only punitive action at HCFA's disposal was total exclusion of a facility from participation in Medicare and Medicaid. This approach was typically used against facilities with long, detailed records of non-compliance.

Congress expanded our flexibility in forcing substandard facilities to achieve minimum quality standards by providing an alternative to decertification of long term care facilities out of compliance with the conditions of participation (Section 916). As an intermediate sanction mechanism, action can be taken to improve a facility before its situation deteriorates to a critical state. The intermediate sanction gives the Secretary the authority to limit reimbursement on future Federal admissions, thereby safeguarding the financial viability of the facility as it takes the necessary steps to come back into compliance.

This intermediate sanction is viewed as a very appropriate tool to bring facilities into compliance with the conditions of participation, because it can be exercised before the situation has deteriorated beyond correction. Secondly, it can be exercised without financially crippling the facility, which would impede the process of achieving compliance. Consequently, the intermediate sanction is preferred to the form of sanction that excludes facilities from participation in the program.

MEDICAID CAP

Mr. Secretary, the Administration has proposed a cap on Medicaid expenditures which would reduce outlays by $1 billion in 1982.

As you are no doubt aware, the National Governors Association and a significant number of other organizations oppose the cap. Most recently, the Senate Budget Committee, not exactly a hotbed of liberalism, also rejected the cap, but instructed the Finance Committee to come up with savings in Medicaid and Medicare totalling roughly $1 billion.

Question: How do you respond to the main criticism of the Medicaid cap proposal, which is that limiting Federal payments for Medicaid will not reduce overall health care costs, but merely transfer these costs to States and counties, and to the private sector?

Answer: Our proposal will provide an incentive to encourage States to more efficiently deliver Medicaid services. This proposal is not intended or expected to result in shifting of excess cost burdens onto State and county governments and private insurers.

The Administration believes that the flexibility given States in this proposal will allow them to modify costly current requirements and provide sufficient savings to offset any limitation on Federal reimbursement. Moreover, capping Federal expenditures will give States additional incentives to reduce fraud, abuse and waste in their State-administered programs. States, therefore, which take advantage of the new flexibilities given to them, should not be forced to increase their level of funding, or that of the counties or the private sector, to pay for the current level of services.

It should be noted specifically, that the proposed cap on Medicaid expenditures does not reduce the Federal spending level below actual FY 1980 expenditures. It does, however, limit the rate of growth in Federal Medicaid spending for FY 1982 to 105% of FY 1981 outlays, and ensures that, thereafter, until permanent reforms can be enacted, the rate of Federal spending would rise only with the rate of inflation.

Question: Under a Medicaid cap, States would presumably have more flexibility to run their Medicaid programs, but would receive considrably less money than they would under the present program structure. The idea of a Medicaid cap is very new and untested.

How do you know that a Medicaid cap would not create a severe burden on State budgets, particularly in States with very high unemployment, or States which have statutory limits on revenues?

Answer: The Administration proposal is intended to give States the opportunity to encourage more efficient delivery of Medicaid services at a lower cost, not to shift an excess cost burden onto State and local governments. Under the proposal, Federal expenditures would be allocated among States so that each State will maintain its current relative share of Medicaid spending.

The Administration believes that the degree of restraint required under the proposal can be achieved by States through the flexibility it allows them to modify costly current requirements and target services more efficiently. The 1982 reduction, for example, amounts to only 3% of the combined Federal-State spending on Medicaid projected by the previous Adminsitration. Capping Federal expenditures will also give States additional incentives to reduce fraud, waste, and abuse in their State-administered programs.

Question: Some States, such as Maryland, have already reduced benefits to Medicaid beneficiaries as a result of budget constraints. Under a cap, might not many other States follow suit and reduce benefits? How can States use less money to provide the same level of benefits?

Answer: Both the States and the Federal government have budget constraints. As you point out under current law States can and do make changes in the benefits they provide. We expect this to continue under our proposal, since it would not require States to maintain the same level of benefits that they currently provide. It would require the States to protect the neediest Medicaid beneficiaries (AFDC and SSI recipients) against loss of basic Medicaid benefits. It would at the same time give States great authority which they do not now have to take steps to make their programs more cost effective without cutting benefits severly. Examples of cost-saving strategies which States could pursue under the proposal without unduly hurting beneficiaries include setting hospital reimbursement rates on other than a reasonable cost basis; using competitive bid and other bulk purchase arrangements; targeting optional services for specific populations or areas; and promoting non-institutional long-term care arrangements.

Because of the flexibility States will have to make their programs more cost effective, we do not expect that the proposal will compel States to make benefit reductions.

It should be stressed that the proposed cap on Medicaid expenditures does not reduce the Federal spending levels below actual FY 80 expenditures. It does limit the rate of growth in Federal Medicaid spending for FY 1982 to 105% of FY 81 outlays, and ensures that, thereafter, (until permanent reforms can be enacted) the rate of Federal spending would rise only with the rate of inflation.

FREEDOM OF CHOICE

Last year, in the Senate's version of the Omnibus Reconciliation Bill, a provision was included that would allow States to choose the providers of services to Medicaid beneficiaries. Thisbecame known as the Freedom of Choice issue, because this amendment would allegedly limit the freedom of Medicaid beneficiaries.

Question: Does the Department of HHS favor giving the States the flexibility to choose who may be the providers of health care to Medicaid beneficiaries? Why?

Answer: The National Governors Association specifically requested that States be given the ability to limit freedom of choice of providers. The proposed Medicaid "cap" would allow States to request a waiver of the "freedom of choice" requirements. We believe that this flexibility is needed to help States check the inflation in the program's costs while providing adequate quality care.

MEDICARE CONTRACTORS

There are two significant cuts within the FY '82 Budget for Medicare contractors which are of concern. One is a reduction of $7.6 million for maintenance and operation of toll-free telephone lines which allow Medicare beneficiaries to call in and ask questions about their Medicare bills or statements.

Question: Why is this service being eliminated?

Answer: Toll-free lines were instituted as a service to the beneficiary which is outside the scope of normal claims processing activities.

The value of this service is questioned by a number of contractors, and in lieu of restricted funding available for FY 1982, it is imperative that all functions which do not directly impact on the primary duty of the contractors--the processing of claims--must either be reduced or eliminated.

MEDICARE CONTRACTORS AUDIT REVIEWS

The FY '82 HCFA Budget shows a reduction of $19 million in audit reviews under the Medicare Contractors account. It is the Committee's understanding that these audits result in $5.00 in denied reimbursements (be they fraudulent or merely miscalculated) for every dollar that is spent on them.

Question: Why does HHS propose a major reduction in such a cost-effective program, especially one which helps control waste?

Answer: It is true that funding for audit and reimbursement activity has been reduced for the level proposed in the previous Administration's budget. This action does not represent a reduction in our program to control waste but an effort to improve management efficiency. Although we are reducing the budget for audit activities, we plan to more effectively target the field audit activities of the intermediaries so that there will be little diminution of audit oversight. We will further improve our system for desk audit of cost reports to minimize improper reimbursement. Finally, we will be closely monitoring the financial status of each contractor's budget so that all additional funds possibly available will be targeted on audit activity.

PSROS AND DEREGULATION

Mr. Secretary, I am aware that this Administration intends to deregulate the health care industry, and hopes that competition rather than regulation can help restrain health care costs. I support these efforts.

On the other hand, I think we can agree that certain legislative changes are required before competitive forces can begin to restrain health care costs. Since this is so, I wonder how wise it is to completely phase out the PSRO program over the next three years, especially in areas where PSROs are effective and popular with the local medical community.

Question: What are your thoughts on this matter?

Answer: Our intent is not to wipe out the PSRO program, but to gradually withdraw Federal support over a three year period. It is expected that effective PSROs will increase their private review efforts and gradually make the transition to full private financial support.

It is our belief that reducing the number of PSROs will not change utilization rates, and thus there will be no adverse impact on utilization rates or on program costs. The initial phase of terminations will be directed towards those PSROs that have been least successful in meeting their program responsibilities, and have had the least impact related to reduced utilization. Consequently, changes in utilization are not expected in these PSRO areas.

Those PSROs that are effective and popular with the local medical community will be in a good position to be of service to State agencies, local private insurers, and hospital consortia, and etc. It is intended that these PSROs will continue to serve their area. They have expertise in medical audit and utilization review, which these agents do not presently have. The reputation that a PSRO has acquired and the respect of the medical community are going to be critical aspects in a successful transition to private review. By continuing in operation,the PSRO's physicians will thus be in a position to use their community stature to influence locally the development of the different forms of health plans, and various health insurance schemes which will be encouraged under the competitive approach. For this added reason, it is not this Administration's intent to extinguish all PSROs, least of all those that have established themselves as a vital part of the local health care community.

PSROs

The Administration is requesting a rescission of roughly $38 million in FY '81 to a level of $135 million in the PSRO program, and an overall program level for FY '82 of $69 million. This is a very precipitous phase down indeed!

Question: How many PSROs will be defunded by FY '81? In FY '82?

Answer: The number of PSROs to be terminated has not been exactly determined. Under the FY '81 revised Reagan budget, total funding is reduced by $38.2 million, and the number of reviews cut back by 2.8 million patients, to 10.3 million.

Approximately 60 PSROs need to be terminated in order to meet the target reduction in reviews and budgetary levels. The number of projects terminated will be determined by the need to meet the budget and review targets. Starting with those lowest ranked PSROs, terminations will occur until the program achieves required budget and review levels.

In FY '82, approximately 40 additional PSRO terminations will need to take place until budgetary and review targets are met. Program funding will be reduced by approximately 50% to $69.5 million from FY '81. The number of reviews is to be reduced by approximately 50% to 5.3 million patients. FY '83 is the final year of Federal grants for PSROs. No additional funding is presently proposed for FY '84.

Question: How precisely will PSROs be chosen for "phase-out"?

Answer: PSROs will be evaluated and ranked using a performance criteria scoring system developed by HCFA. The evaluation instrument was circulated for comment to the Regional components, PSROs, and several organizations, including the American Association of Professional Standards Review Organizations.

On the basis of PSRO comments, and Regional Office input, the Performance Evaluation Criteria has been finalized. It will be used by project officers to evaluate PSRO performance. Once completed, the materials on each PSRO will be forwarded to HCFA where PSROs will be ranked nationally, and notified of their ranking by late-May.

The Performance Evaluation Criteria involves a point system covering three areas, with additional bonus points: Organization and Program Management, Performance of Review-Operations, Performance of Review-Impact, and Bonus Points for Additional Review Activities and Special Contributions to the Art of PSRO Review. More than half of the points are allocated to PSRO impact, or potential impact, especially in the areas of utilization and quality.

An effort was made in the development of the criteria to account for the younger PSROs that have not had the benefit of the years of review experience the earliest funded PSROs have had, but which have the potential to continue to flourish in their areas. This is in recognition of the fact that some of the youngest PSROs have shown greater innovation in their review systems, especially related to focused review. These newer PSROs will not be penalized for their shorter period of operation.

Question: What indices does HHS use to determine which PSROs are effective and which are ineffective?

Answer: The following list details the specific categories covered by the PSRO Evaluation Criteria,

I. Organization and Program Management

+ Board and Committee Commitment
+ Administrative and Financial Management
+ Cost Efficiency

II. Performance of Review Operations-Compliance and Process

+ Acute Care Review
+ Special Actions to Address Identified Problems
+ Medical Care Evaluation Studies
+ Data
+ Profiles

III. Performance of Review-Impact/Potential Impact

+ Management-Objectives
+ Impact-Utilization Objectives
+ Impact-Quality

Bonus Points:

+ Additional Review Activities
+ Special Contributions to the Art of PSRO Review

Question: For the Record, provide a list of those PSROs you plan to close in FY '81 and in FY '82.

Answer: The ranking of PSROs has not been completed. It is expected to be available by late May. The PSROs to be terminated in this initial phase will be identified and notified once the national ranking has been completed.

Impact of Welfare Cuts on Medicaid

If Congress approves the reductions in eligibility under the AFDC program, there should be a corresponding reduction in Medicaid costs since all AFDC recipients automatically qualify for Medicaid. If we assume the Medicaid cap is imposed, all of the reduced Medicaid costs should accrue to the States.

Question: What is your estimate of the decrease in State Medicaid costs stemming from the reduced eligibility for AFDC?

Answer: Approximately 1.1 million individuals currently receiving AFDC payments would no longer be eligible for AFDC based on proposed program reductions. Some of these are children 18-20 years old and adults associated with that family unit, who would no longer be categorically-eligible for AFDC, or therefore for Medicaid.

Of the 1.1 million total, 60 percent have incomes which would exceed the AFDC standards and live in the 30 States with medically needy programs. Approximately 19 percent of these persons have incomes below the medically needy level and could be eligible on that basis.

Some of the remainder of individuals with incomes above the medically needy standard in their State would be likely to "spend-down" into Medicaid. It is impossible, however, to estimate this number.

Specific information is not yet available on how these caseload impacts will affect Medicaid costs. When this information becomes available, the Department will provide it to you.

Question: To what extent can these savings be used to offset the cuts in the health and social services block grant proposal?

Answer: The flexibility that States will have under the block grant and Medicaid programs will enable them to make these programs more complementary.

Since, under the cap, States will be given greater discretion in administering their Medicaid programs, it is possible that they could use Medicaid funding for some services that are not provided through the block grants.

PROGRAM ADMINISTRATION (PRODUCTIVITY)

In FY 82, the HHS budget request for HCFA Program Administration declines significantly below the Carter Budget, leaving roughly 4,871 positions in HCFA, a decrease of 128 below the FY 81 level.

Question: How do you know whether that is too much or too little?

Answer: Our staffing request was developed on the basis of revised program requirements. HCFA workload will experience a decline associated with program reductions which are being achieved either as a result of the Administration's deregulation efforts or administrative improvements.

Question: How is worker productivity measured?

Answer: At the present time we have in place a cost allocation system which requires development of staffing plans by organization, program and function. Actual experience is reported on a quarterly basis and matched against initial planning figures. When properly evaluated, these data assist agency managers in measuring movement in employee productivity.

We believe HCFA has a proven track record in doing more for less. In 1978, the first full year of HCFA operation, this agency had 4,400 authorized positions; in 1982, we are requesting 4,871 positions. This is an increase of 471 positions over 4 years, but the increase is more apparent than real. Over 400 of these positions were transferred from the Social Security Administration for functions which were reassigned to HCFA.

As you can see, this agency's size has remained essentially static despite the growth of its programs and their increasing complexity.

Question: How do you know that the same amount of work that is presently performed by HCFA could not be done with 1/3 less people?

Answer: HCFA has remained a small agency, notwithstanding the dynamic environment of health care programs. We have been able to accomplish this by reallocating staff as needed in order to be responsive to shifting agency priorities and by establishing effective links with other Federal and State agencies so as to avoid program overlap.

As we have mentioned previously, over the years HCFA programs have grown both in size and complexity, yet we have managed to maintain essentially static employment levels. We feel the record shows we have been successful in maximizing our limited personnel resources.

WASTE, FRAUD AND ABUSE

Question: List all the specific reductions below the Carter request proposed for fiscal years 1981 and 1982 that can be specifically attributed to the elimination of waste, fraud and abuse.

Answer: Specific 1982 revised budget proposals, over and above those included in the 1982 Carter budget, designed to eliminate fraud, and abuse, include:

	Outlay Savings in millions	
	1981	1982
o Disability reviews: Control of the Social Security disability program will be strengthened by efforts to remove ineligible individuals from the rolls....................	$50	$200
o Adopting retrospective accounting system in SSI: Legislation is proposed to convert the current prospective system of recording changes in earnings, living arrangements and related eligibility factors to a retrospective accounting		

	Outlay Savings in millions	
	1981	1982
system. This system should reduce errors and assure proper payment levels............	--	60
o SSI automated interface with IRS: Savings will result from coordination with Internal Revenue Service to improve timely identification of bank accounts and interest and dividend income. This initiative should also reduce errors and incorrect payments.................	--	51
o Child support enforcement proposals: Additional legislative proposals are included in the revised budget to tighten the child support enforcement program. (Several legislative proposals were already included in the Carter budget totalling $125 million in 1982.) These new provisions, which are specifically designed to reduce fraud, waste and abuse, include a proposal to require IRS to intercept Federal income tax refunds to collect child support arrearages from liable absent parents and to prohibit absent parents from discharging child support obligations when they declare bankruptcy...............	--	-44

In addition, many of the new legislative proposals to reform the Aid to Families with Dependent Children are designed to improve the administration of the program, reduce administrative costs, and eliminate waste by introducing systematic, business-like methods of securing and processing information about applicants and recipients.

Also included in the revised budget is a proposal to place a ceiling on Federal Medicaid funding to limit the growth of this program. This limit would slow down the tremendous rate of increase experienced in this program and would save $0.1 billion in 1981 and $1.0 billion in 1982. Under This proposal, States will have every incentive to contain fraud, abuse and waste and to manage their program more effectively. States, under this proposal, would have every incentive to make maximum use of tools like third party collections, Fraud Control Units and Medicaid Management Information Systems. Also, the flexibility granted to States will enable them to develop new methods that are appropriate to their unique situation.

In addition, the Department has an extensive on-going program to combat fraud, abuse, and waste. Pending an indepth review of this program, it is being continued as presently structured. However, I am confident that over the next few weeks, as we complete the filling of leadership positions in the Department, additional initiatives will be developed.

Transfer of Elderly Nutrition Program

Q. Doesn't such a transfer require authorizing legislation--or just how far do you plan to proceed administratively to implement this transfer?

A. The President's proposed Older Americans Act Amendments which will be available to Congress shortly provides for these funds to be transferred in fiscal year 1982.

Q. Exactly how much will be transferred to HHS for nutrition for the elderly in fiscal 1981?

A. The transfer of Agriculture Department funds to HHS will take place in fiscal year 1982. The amount included in the President's request for the Administration on Aging which, in the January FY 1982 budget was requested for the Department of Agriculture, is $95,480,000.

Q. How many meals will be supported by Federal funds in fiscal year 1982, compared to fiscal 1981, from the combined total of HHS and Agriculture Department nutritional programs for the elderly?

A. The total number of meals served in both fiscal years 1981 and 1982 will be approximately 161 million, or 611,000 per day. Department of Agriculture, Administration on Aging and State and local matching funds support this level of service.

SSA's CONTINGENCY RESERVE

Question: The Reagan Administration has requested an additional $67.6 million for the contingency reserve in the Limitation on Administrative Expenses, in order to make sure that all of the work required to implement the President's Social Security initiatives can be accomplished quickly after enactment of the Administration's proposals. Under the current hiring freeze, does the Social Security Administration have the staff necessary to implement these changes?

Answer: At this time, SSA does not have staff on-board to implement the President's legislative proposals. Most of this work is one-time in nature. As a result, we plan to use term employees supplemented by additional overtime. Hiring terms, with time-limited appointments, does not constitute a permanent addition to the Federal work force. These employees will be brought on-board if and when the President's proposals are enacted.

Question: What is the staffing level as of today of the Social Security Administration?

Answer: Excluding special ceiling exempt employees, such as worker trainees, staffing now stands at 82,660. This total includes 73,202 full-time permanent, 6,509 part-time permanent and 2,949 temporary employees.

Question: Why is $67 million necessary? Why not less?

Answer: This add-on for new legislation represents "ball park" estimates developed by the agency before the legislation proposed by the President was fully drafted. The estimates assume manual processing in such areas as elimination of the minimum social security benefit.

FUNDING FOR SURVEY OF INCOME AND PROGRAM PARTICIPATION

Question: Why has the Administration decided to request funds for this project?

Answer: The SIPP has been designed to obtain information on the combined impact of cash and in-kind benefit programs. These programs make up a significant part of HHS and of Federal spending. The present sources of data do not fully meet these information needs. Data on income, assets, and other characteristics that determine eligibility and the amount of payments cannot be completely obtained from surveys designed for other purposes, such as measuring employment levels. Accordingly, the Administration has decided to request funding for SIPP for FY 1982.

Question: How much will this study cost by the time it is completed?

Answer: The proposed SIPP panel will extend over FY 1982 and FY 1983. In addition to the $8 million now requested for FY 1982, an estimated $7 million will be required in FY 1983 to complete the full cycle of interviews. If the 1982 Panel is as useful as expected, the panel could be extended for another year, or a new panel begun, but this is a separate decision. No spending beyond the $15 million in FY 1982-FY 1983 is implied in this request.

PURPOSE OF SURVEY OF INCOME AND PROGRAM PARTICIPATION

Question: What will this study attempt to learn?

Answer: The SIPP has been designed to link information collected in household interviews with appropriate information from administrative records. This information will be used to address the following:

Calculating the combined effect of different programs. People can receive benefits from more than one program-e.g., AFDC and Medicaid. It is difficult to assess the combined effect, because program records are kept separately, and existing surveys cannot measure benefits as asset-holding adequately. SIPP data will make it more possible to assess the combined benefits for particular groups.

Calculating the individual effects of program changes. Changes in eligibility rules or benefit levels raise the question of how various individuals fare. Such analysis is needed in order to make efficient use of resources.

Program cost estimates. Changes in program rules and the economy have an effect on outlays that is frequently uncertain. SIPP is designed to assist in the preparation of Departmental cost estimates.

Poverty status. Current poverty measures rely only on cash income and family size and do not consider in-kind assistance. SIPP data can be used to see whether current poverty measures are appropriate indicators for different groups.

Movement in and out of poverty and dependency. The panel design, which follows people and makes month-to-month measures of their reported situation, provides data to measure the movement of persons in and out of poverty and public assistance status. Measuring assets, private assistance, and job status also can indicate whether apparent changes in poverty status reflect changes in self-support or dependency, and the impact of changes in benefits and the economy.

Taxation. SIPP will collect the data needed to calculate income and retirement taxes relative to total--not just taxable--income. SIPP can be used to estimate the impact of changes such as deductions or credits.

Special issues. The SIPP can be used instead of having separate special-purpose surveys, with a possible savings in costs. For example, the 1982 SIPP is intended to replace an old-age and retirement study for the Social Security Administration.

CHILD SUPPORT SERVICES FOR NON-AFDC FAMILIES

Question: The Administration is proposing a number of changes in the Child Support Enforcement Program. Among these is a proposal to retain up to 10 percent of collections made on behalf of non-AFDC families as a fee to cover the cost of service.

Might not this provision effectively punish abondoned mothers by taking away from their child support income? Why?

Answer: First, let me point out that existing law allows the States to charge an application fee for non-AFDC child support services and deduct any administrative costs in excess of the application fee from future collections. Thus in some cases under existing law more than 10 percent of collections may be withheld from mothers.

We believe that non-AFDC families are receiving a very valuable service that is for all practical purposes unavailable from any other source. We do not believe it is inequitable to have families share in the cost of this service. In the absence of the Child Support Enforcement program, most of these families would receive no child support since even if a private attorney could provide a comparable service it would be very costly. Consequently, we do not believe that paying families 90 percent of what might otherwise be totally unavailable is unreasonable.

EFFECT OF FEE ON NON-AFDC MOTHERS

Question: Isn't it possible that a non-AFDC mother would drop onto the AFDC roles rather than have her child-support reduced?

Answer: New applicants for non-AFDC support services are, by definition, not on welfare, either by choice or because of ineligibility. Therefore, we would not expect these women to go on AFDC after they begin receiving child support payments. Since they have not been on AFDC in the absence of child support, it does not seem logical to assume they would later go on AFDC because they are receiving 90 percent instead of 100 percent of additional income in the form of child support.

It is possible that some women who are currently receiving child support might decide to go on AFDC (assuming eligibility) if the amount of their child support were reduced by 10 percent. While it is not possible to estimate how many might do so, we do not believe it would be a significant number. We considered proposing that the 10 percent fee be waived if it would result in AFDC eligibility, but concluded that the administrative costs of making this determination would outweigh its benefits.

PROPOSAL TO LEVY SURCHARGE ON ABSENT FATHERS

Question: Has the Department considered levying a 10 percent surcharge on absent fathers from whom child support payments are collected, rather than charging the mother? What are the advantages and disadvantages of this approach?

Answer: We have considered levying the fee on the absent parent rather than the mother. We agree that it is preferable to hold the absent parent responsible for costs rather than the mother. Unfortunately, we do not believe this approach would achieve a significant reduction in non-AFDC costs. It is very difficult to collect the full amount of the child support obligation from absent parents. It would be harder yet to collect an additional 10 percent from each absent parent. We believe that very little of the 10 percent surcharge could be collected, resulting in minor budget savings. Furthermore, assuming we can compel courts to add 10 percent to absent parents' support obligations, the fact that the amount of the support obligations is usually based on the ability to pay would probably result in adjusting the basic support obligation downward. In other words, the net result to the mother would probably be the same whether the absent parent is required to pay the 10 percent levy or whether it is deducted from her support payment.

PROPOSED LIMIT ON AFDC DISREGARD

Question: The Administration is proposing to limit the so-called $30 and 1/3 income disregard for AFDC recipients to 4 months. This income disregard is considered an incentive to AFDC parents to get them to work.

- If this change is enacted, won't this be an incentive to stop working and stay on AFDC?
- How much is this change supposed to save?

(NOTE: An AFDC recipient who works may currently disregard $30 and 1/3 of his or her income for tax purposes; this disregard was established because if the full income of an AFDC beneficiary working at the minimum wage is taxed, the AFDC beneficiary might earn less than if he or she did not work at all and simply lived on AFDC benefits.)

Answer: Program data show that the percentage of AFDC parents who work has not significantly increased since the inception of the $30 and 1/3 disregard in 1968 and that the percentage of cases leaving the AFDC rolls due to employment has sharply decreased since that time. (See table at end of discussion.) These figures, as well as a number of research studies, show that the earned income disregards are not effective in encouraging more recipients to work. Rather, the disregards promote continued dependence on welfare by allowing recipients to increase their earnings and still remain on welfare.

We believe that allowing the disregard for 4 months provides adequate financial support during the period of transition into employment. After this adjustment period the recipient has clearly demonstrated that he or she is capable of working, so that a continued disregard becomes an income supplement, rather than an incentive.

Furthermore, we are proposing a work requirement, not a work incentive. Those who are capable of working will be required to do so, either in the regular economy or as part of the proposed community work experience program (CWEP). Since jobs in the regular economy offer greater potential financial rewards than CWEP participation, we expect recipients will voluntarily seek the more financially attractive alternative.

The change is expected to save about $171 million (in Federal funds) in FY 1982, of which $145 million represents actual program savings and $26 million is administrative savings. This estimate represents the incremental savings from this change assuming that four other proposed changes--counting stepparent's and other persons' income, eliminating payments for children over age 18, assumed advance receipt of EITC, and changes to the earnings disregard (standardizing work expenses, capping child care and applying the $30 and 1/3 to remaining net income)--are enacted.

	Percent of AFDC Mothers with Earnings	Percent of AFDC Discontinuations Due to Employment of Increased Earnings
1961	12.5%	--
1967	13.4	27.5
1969	13.7	27.5
1971	13.7	22.1
1973	14.4	17.9
1975	13.7	12.3
1977	12.3	13.6
1979	12.0	13.3

Source: SSA, Office of Research and Statistics (AFDC Characteristics Survey and ORS Report A-12)

Note: The parenthetical note at the end of the question appears to imply that the present policy allows a $30 and 1/3 disregard for income tax purposes. This is not correct--the policy allows some earnings, which would otherwise reduce the AFDC benefit amount, to be disregarded during the AFDC benefit computation. The policy affects the AFDC program only, and has no effect on income tax liability.

It should also be clarified that for AFDC purposes all income taxes are disregarded from countable earnings through a separate disregard which specifically considers work-related expenses such as taxes.

EMERGENCY AND ENERGY ASSISTANCE BLOCKGRANTS

Question: The total amount appropriated in FY '81 for the low-income energy program and the emergency assistance program was more than $1.9 billion. The FY '82 request for the energy and emergency assistance block grant is $1.4 billion. This block grant, unlike others the Department is recommending, consolidates only two relatively distinct programs.

Since the Administration has de-controlled the price of oil, and plans to decontrol the price of natural gas, moves, I might add, which I support, how are States supposed to use less money to pay for higher and higher-priced energy?

Answer: The first priority of this Administration is to bring government spending under control. We believe the cost of assistance programs can be trimmed without reducing aid to those most in need. Federal requirements and restrictions in the present programs complicate administration and add to the cost of the program. Under our block grant proposal, the States will have greatly increased flexibility to design programs to respond to new and changing conditions and adjust to local needs where, in the past, nationwide requirements have restricted their options. We believe the effect of the dollar reductions will be offset in part by the savings States will realize by freeing them from non=productive uses of program funds such as Federal paperwork and program requirements and by allowing States to target funds more efficiently to best meet the needs of their residents. Also, our plan has built-in features which allow States to respond to changing conditions: States would have 2 years to spend their yearly allocation, which allows a buffer amount to respond to unpredictable weather-related emergencies, and States can transfer up to 10 percent of the other HHS block grants to this program, if that is where the funds are most urgently needed.

Incidentally, I'd like to point out that as of late April the Administration has not developed or announced plans for accelerated decontrol of natural gas.

MINIMUM BENEFIT AND SSI

Question: The FY '82 Reagan budget estimate for SSI benefits is $115 million lower than the Carter Administration FY '81 request. Yet, the Reagan Administration has admitted that SSI costs will increase if the Social Security minimum benefit is eliminated. How much will SSI costs increase if the minimum benefit is removed?

Answer: SSI costs will increase by an estimated $300 million in FY's 1982 and 1983 as a result of eliminating the minimum benefit payment policy. The costs are expected to increase by $400 million beginning FY 1984.

Refugee Flows

Question: Has there been any discussion within the Administration on the possibility of limiting refugee flows into the United States in FY '82?

Answer: The question of refugee admissions levels for FY 1982 has been the subject of on-going review and discussion within the Administration throughout this fiscal year. The Administration budget request now before the Congress would finance up to 187,000 refugee admissions next year (as opposed to 217,000 for FY 1981). However, the authorized level will not be set until September, 1981, after the President has completed consultations with the Congress as required by the Refugee Act of 1980.

Question: What are the current official, State Department estimates of the number of Southeast Asian refugees, Soviet refugees, and all others to enter the United States?

Answer: The official number of refugees to enter the United States during FY 1981 is 217,000:

- 168,000 from Southeast Asia,
- 33,000 from the Soviet Union,
- 4,500 from Eastern Europe,
- 4,500 from the Near East,
- 4,000 from Latin America, and
- 3,000 from Africa.

These numbers were established after a series of consultations were held between Congress and the President prior to the beginning of FY 1981.

Social Services

Question: The Reagan budget for the Office of Refugee Resettlement proposed reducing funding for refugee social services by $23 million below the FY 81 level. Some states, such as California, claim they have thousands of refugees who are on waiting lists for basic services such as English-as-a-Second-Language (ESL) classes. If Southeast Asian refugees are to become self-reliant doesn't it seem evident that they will require social services to enable them to do so?

Answer: The Administration fully recognizes the need for social services programs for refugees to enable them to become self-reliant. In FY 1982, the Administration intends to focus its refugee social services monies on services which lead to employment and economic self-sufficiency.

Question: What initiatives does the Reagan Administration plan in order to hasten the process through which refugees become self-reliant?

Answer: The Department of Health and Human Services is now in the process of developing detailed policy governing States' use of refugee social services funds. The new policy would clarify and strengthen guidance provided to States in August, 1979. Although details have not yet been finalized, the central feature of the new policy is the prioritizing of services intended to lead to employment and economic self-sufficiency for refugees.

Question: Why does the Administration propose a reduction in social service funding?

Answer: The FY 1982 revised request for social services is less than the FY 1981 revised request for two reasons. First, the number of new refugees expected to arrive in 1982 is 26,500 less than the 1981 admissions level. Second, ORR will concentrate social services funds on those activities which foster self-sufficiency, such as English language training and vocational training.

Cuban and Haitian Unaccompanied Minors

Question: An article in the Wisconsin State Journal indicates the Department is spending an average of $80,000 for each Cuban youth refugee in the state. The article also reported that one academy housing 24 Cuban juveniles had a full-time staff of 31 -- or more than one staff person for each refugee. Do you regard a sum of $80,000 per person as being a reasonable amount to assist Cuban youth refugees?

Answer: We are aware of the article in the Wisconsin State Journal, and are planning a careful review to uncover the facts. The expenditure of $80,000 per Cuban youth appears to be unreasonable and may not be accurate. We understand that this figure is an annual cost estimate derived from the actual costs incurred only during the first quarter of FY 1981. Costs in the first quarter were much higher than those for the succeeding three quarters are expected to be for two reasons. First, the start-up costs of the agencies with whom Wisconsin Department of Health and Social Services contracted for the care of the minors were included in the first quarter costs and then extended as yearly costs. Such costs include recruitment and training of staff and foster parents, renovations of facilities, and purchases of winter clothing for the children. Such costs occur only once per contract, and should not be projected into a yearly contract cost. Second, the operation of the camp at Wyalusing State Park by the state of Wisconsin ended in December, 1980, after only six weeks of operations, yet these costs were also extended as yearly costs.

Question: What is the amount budgeted per youth refugee for fiscal year 1982 on a nation-wide basis?

Answer: The FY 1982 budget request for care of unaccompanied minors is $20 million. This figure is $11 million less than the FY 1981 budget due to the large number of minors who are expected to reach majority status during this period, i.e. eighteen years of age or such higher age as designated in each State's child welfare services plan. Expenditures for FY 1982 are projected to averaged $12,000 per child, which includes administration of the program and direct care and services to the minors.

DEPARTMENTAL MANAGEMENT PAY RAISE SUPPLEMENTALS

Question: The Department is requesting a supplemental for Fiscal Year 1981 in the amount of $9,116,000. Your written justification indicates that your actual need is $9.416 million, but that you will be absorbing 3 percent of that amount or $300,000. How do you plan to "absorb" the additional $300,000 you need, but are not requesting?

Answer: The revised FY 1981 pay raise supplemental request for General Departmental Management is $9,116,000, $300,000 less than the original supplemental forwarded to Congress in January. The $300,000 reduction in FY 1981 funds will be effected by cutting travel costs by $150,000, procurements of furniture by $85,000 and consultant service contracts by $65,000.

Question: In these days of fiscal restraint and belt tightening, how can you explain such a small decrease in your supplemental request? The Department of Labor is absorbing 87 percent of their salary increases incurred last October, and the Department of Education is absorbing 14 percent of their salary increases, whereas your Department is absorbing only 3%.

Answer: Of the $342,199,000 needed by the Department to fully fund increased pay costs due to the October 1980 pay raise, $125,941,000 or approximately 37% was to be absorbed. Within the remaining $216,258,000 that was requested on March 10, $9,116,000 was thought to be necessary to supplement the FY 1981 GDM appropriation. Since the revised supplementals were provided to the Congress, we have reviewed all appropriations in Departmental Management and identified an additional $3,800,000 which can be transferred to GDM from the Office of the Inspector General, thereby increasing the amount of the pay raise absorption to a total of $5,800,000 or 62%. Further reductions are simply not feasible.

Question: What would be the effect, should Congress not agree to the supplemental request of $9,116,000?

Answer: The General Departmental Management (GDM) appropriation is a salaries and expenses appropriation and, as such, approximately 76% of its funds go to support employee salary and benefit costs, unlike program appropriations in which salaries and benefits amount to a much smaller percentage of the total. For this reason, the GDM account has much less flexibility in absorbing large portions of any increased pay costs.

In addition to this, the FY 1981 budget for GDM has experienced a number of reductions--totalling $7.6 million--including Carter administrative reductions, Congressional reductions, and reductions recently made by the new Administration. For the period of FY 1979 to 1981 the GDM budget requests have been reduced by more than $11 million. These reductions have resulted in a significant erosion of the GDM "base" to the point that there are very few areas in which any additional absorption could take place.

Should Congress decide not to recommend funding of the supplemental request of $12.4 million for the Office of the Secretary, a total of $8.8 million could be absorbed. The Office of the Inspector General (OIG) has identified $2.2 million that could be transferred from the State Medicaid Fraud Control Units (SMFCU) program and used to absorb its total pay raise request and the Office for Civil Rights can absorb its $1.1 million pay raise need. In addition, OS has identified $5.5 million that could be transferred from other OS appropriations to partially offset the GDM pay raise supplemental request of $9,116,000: a re-estimate of the funding needs for the SMFCU program in OIG has yielded $4.8 million no longer required in FY 1981 which could be transferred to the GDM appropriation to support its pay raise needs and $0.7 that could be transferred from the Policy Research appropriation, for a total of $5.5 million to be transferred. This results in a shortfall of $3.6 million still required to support the GDM pay raise supplemental request.

GDM cannot effect an absorption of this shortfall. The only significant variable in GDM's ability to successfully absorb any more than the $300,000 mentioned above is in the level of staffing. Recognizing this fact, GDM staffing levels have already been reduced through various administrative actions, to a current level of approximately 87% of the budgeted positions, 10% below the "normal" staffing level of 97%. These reductions have been planned and implemented over the past months of both the Carter and Reagan Administrations. Additional reductions on the scale necessary to save $3.6 million over the next few months are impossible.

Extension of an absolute hiring freeze through the end of the fiscal year would save less than $200,000 and would leave GDM staffed at a level insufficient to insure the Secretary's ability to fulfill his responsibilities. Even if one eliminates all considerations of maintaining effective management of the Department, a reduction in force action, implemented May 1, 1981, could not lay-off employees in sufficient numbers and within such a short time frame to produce $3.6 million net savings between payroll reductions and cost increases associated with termination expenses.

Question: Unlike most other administrative offices in the Deparcment, the Office for Civil Rights has not been requested to absorb any of its $1,116,000 in salary increases, and is requesting a supplemental for Fiscal 1981 in that amount. How much of that supplemental can the Office absorb without having to reduce staff, beyond attrition?

Answer: The Office for Civil Rights had not been asked to absorb any of its $1,116,000 in salary increases because at the time funds provided under the Continuing Resolution for Fiscal 1981 were deemed to be insufficient to support the staffing level and ongoing activities. However, upon reexamination of our financial status it appears that this supplemental is not needed for the pay raise because of the large number of vacancies caused by the hiring freeze. Sufficient funds are now available under the Continuing Resolution for Fiscal 1981.

Question: What would be the effect, should the Congress not agree to the supplemental request of $1,116,000 for Fiscal 1981?

Answer: As indicated above the Office for Civil Rights would be able to absorb the supplemental request because of vacancy rates, attrition and existing hiring restrictions.

GAO Recommendations on Health Programs

Question: On November 13, 1979, the General Accounting Office issued a summary of its reports on our health programs, The GAO found that 84 of its reports issued from 1974 through 1978 contained 262 cost-saving recommendations and that as of November of 1979, only 98 had been adopted. The GAO said that millions more could be saved if the remaining 164 recommendations were put into effect.

Last year, during this Subcommittee's hearings, you pressed Secretary Harris to follow up on these recommendations.

What progress have you made in implementing the remaining 164 GAO recommendations?

Answer: The recommendations of the GAO report were directed to Department of Defense, the Veterans Administration and to the State Department, as well as to the Department of Health and Human Services. Of the recommendations directed to this Department, those with significant cost-savings potential were incorporated into the Departments' FY 1980 and FY 1981 program initiatives. The remainder of the recommendations directed to this Department have implemented or were discussed as exceptions in the Department's report to the Senate Committee on Appropriations on the status of the GAO recommendatins. That report was transmitted to the Chairman and to the Ranking Minority Member on April 8, 1980.

Staff Utilization

Question: What is the Department's Policy for allocating positions to a program?

Answer: The number of positions requested for operation of each program is an integral part of each budget proposal and is shown in the justifications and other supporting materials provided to the Congress with the budget request. That staffing allowance for each program is initially the Secretary's decision based on submissions from the Primary Operating Components of the Department and recommendations of his staff; the final staffing allowance as shown in the budget request to the Congress reflects the agreement of the Secretary and the Director, OMB as to the most appropriate number of positions for each program. Subsequent adjustments to these position levels depend upon action of the Congress in the appropriations process. Permanent positions for each appropriation, as shown in the justification material, represent an upper limit which, normally, cannot be exceeded without Congressional approval.

Personnel Ceilings

Question: The Carter budget proposed to end fiscal year 1981 with 154,500 civilian employees at the Department of Health and Human Services. The revised Reagan budget plans on 155,500 employees by the end of fiscal year 1982. This is an increase of 1,000 jobs over the Carter base, an increase of more than one-half of one percent. By way of contrast, projected employment at Labor is down 7%, at Education it is down 11%, and at HUD it is down 7%, government-wide, 1982 employment is projected at 1% below the Carter base for 1981. Nondefense employment is projected at 4% below the Carter base.

When employment is being cut back sharply in virtually every nondefense agency, why does the Department of Health and Human Services need 1,000 new employees to do its job?

Answer: The revised budget does reduce fiscal year 1982 employment levels in each major component of the Department, with an exception for the Social Security Administration:

	End-of-Year Employment Estimates		
	January Budget 1981	Revised Budget 1982	Change
Public Health Service	58,286	50,984	-7,302
Health Care Financing Admin.	5,113	4,932	- 181
Office of Human Development Service	1,700	1,499	- 201
Office of Refugee Resettlement	147	141	- 6
Office of the Secretary	6,263	5,944	- 319
Sub-total	71,509	63,500	-8,009
Social Security Admin.	83,041	92,000	+8,959
Total	154,550	155,500	+ 950

For other than Social Security, the revised budget reflects a decrease of 11 percent which compares favorably with reductions in other Departments. An exception to permit a growth in employment by the Social Security Administration is for response to new workloads under current law and under proposed legislation as follows:

Under Current Law

A 4,259 employee increase, including 1,450 temporary or term appointees. Principal reasons for this increase include (1) implementation of the Social Security Disability Amendments of 1980 (P.L. 96-265), (2) an increase in the number of continuing disability investigations in an effort to remove ineligibles from the benefit rolls and to reduce program costs, and (3) an increase in staffing for SSA's Office of Systems which needs to hire more programmers and systems experts to speed automation of workload processes and to implement new legislation.

Under Proposed Law

A 4,700 employee increase, including only term appointees, is to complete the one-time work to be started in FY 1981, upon enactment of legislative proposals which would change or eliminate certain benefits paid through the Social Security Administration.

These proposed increases for SSA are essential for successfully carrying out the President's budget proposals and policies.

Question: What program evaluation projects are planned for Fiscal Year 1982?

The following evaluations initiated in prior years will remain active in Fiscal Year 1982:

Longitudinal Evaluation of the Nutrition Program for the Elderly

Rural areas and Small Communities Recreation Assessment (with The Department of Interior)

HUD Congregate Housing Evaluation (with The Department of Housing and Urban Development)

Evaluation of Long-Term Care Channeling Demonstrations

Evaluation of Title VI Grants for Indian Tribes

Strategy Evaluation for the Provision of Training and Technical Assistance.

Evaluation of State Education and Training

Assessment of the Adequacy of In-Home Services

Assessment of the Adequacy of Adult Day Care and Related Services

In addition to the evaluations described earlier, the above list includes the following evaluations:

o Rural Areas and Small Communities Assessment: The overall objectives of this assessment are to: determine the recreation, cultural, and open space needs of rural residents; develop positive Federal policy directions to expand the delivery of recreation services in rural States and communities; and focus attention on the unmet recreation needs of special rural populations, such as the aging.

o Evaluation of Grants to Indian Tribes for Social and Nutritional Services: Determine to what extent essential components of the Title VI program have been implemented; develop a typology of projects which can serve as the basis for comparative analysis; obtain information on obstacles to full operation of the Title VI program; ascertain factors which differentiate projects which have operational programs from those which have been plagued with problems; improve AoA's planning and policy-making capabilities with regard to Title VI through study and analysis of projects, their variations, the factors related to their variations, and types of resourcefulness in service delivery and management undertaken to achieve Title VI program goals; and review, analyze, and improve the Title VI reporting system, including management approaches to data collection.

Strategy Evaluation for the Provision of Training and Technical Assistance: This project will evaluate alternative methods of providing training and technical assistance to the network of agencies serving older people. It will investigate and compare alternate strategies for the use of a wide range of advance techniques and technologies available or becoming available for the interactive transmission of information.

o Evaluation of State Education and Training Program: The Purpose of this study is to conduct a program performance evaluation of the State Education and Trainiing Program authorized under Title IV-A of the Older Americans Act. Results obtained from the evaluation study will be of use to administrators, policy-makers, and program managers who are concerned with providing education and training to staff of State and Area Agencies on Aging, and other personnel who are responsible for providing services to the elderly population throughout the United States. The objectives of this study are as follows: to provide, in a systematic fashion, successive increments of information on the State Education and Training Program potential and program performance; to define the State Education and Training Program activities, objectives, its managers' and policy-makers' information needs and priorities, and determine how the program is performing in terms of agreed-upon objectives and performance indicators; and to provide alternative designs for performance evaluation if the program performance information collected during this study indicate that additional information is needed and is likely to be useful.

Assessment of the Adequacy of In-Home Services: This project will identify providers and the in-home services currently being provided to the elderly and disabled, will develop criteria for determining the adequacy of these services, and will (on a selective basis) assess the adequacy of services currently being provided.

o Assessment of The Adequacy of Adult Day Care and Related Services: The purpose of this procurement is to develop guideline criteria for assessing the adequacy of adult day care and related services in meeting the needs of the elderly. The criterial will be pilot tested and the results will be used by providers to perform self-assessment. The project will provide: (a) A systematic collection of information on adult care and related services. (b) A basis for assessing the adequacy of adult day care. It is anticipated that more than two models with different goals and services will be identified. Cost factors can then be considered in relation to the types of services which are offered. The information derived from this study will form a basis for developing guideline criteria for assessing the adequacy of adult day care and related services which are currently being provided. Results from this project can be used by program managers and policy makers to determine when and under what conditions the identified services best meet client needs and which client groups are most appropriately served by this cluster of services.

New evaluation initiatives for Fiscal Year 1982 are now being developed. Attention is focussing on those efforts that will contribute to the development of comprehensive and coordinated community services systems under Title III of the Act. This will likely include projects aimed at enhancing the capacity of State and area agencies to carry out the evaluation responsibilities assigned them by Title III of the Act, producing policy evaluation studies in areas of substantive concern to older persons, for example, housing, and producing information for decision makers at the Federal, State and local levels related to specific areas of services provision.

Question: How is personnel utilization measured and how frequently?

Answer: The Department currently has the capability to measure the activities of a large portion of its staff resources.

The Social Security Administration and the Public Health Service, the Department's two largest components which comprise 91% of HHS' total personnel complement, have formal productivity systems in place. These systems are ongoing, new data are entered throughout each fiscal year, and the results of the systems are used as part of the budget preparation process. The Department's three remaining components -- the Office of Human Development Services, the Health Care Financing Administration and the Office of the Secretary do not have comprehensive formal systems in place. However, there is active work underway to develop such systems for some of the larger sub-components in these organizations. Finally, the Department does have in place a management-by-objectives (MBO) system for monitoring major operational activities Department-wide, and has a resource component which measures, on a quarterly basis, the amount of staff years planned and expended on each initiative.

INSPECTOR GENERAL'S REPORT ON OVERTIME

Question: What are you doing to correct the problems identified in the recent Inspector General's Report concerning sloppy handling of more than $250,000 in Department overtime?

Answer: As the Secretary of Health and Human Services, I am very concerned about fraud and abuse in any of the programs administered by the Department. To that same extent, I am also determined to eliminate waste, fraud, and abuse found in any of the Department's administrative processes.

The report did not indicate that any of the overtime instances reviewed were fraudulent. However, it does make clear that inadequate exercises of controls at the worksite, and inadequate reviews and control of time cards in the payment process, offer much potential for abuse.

To correct those deficiencies cited in the Inspector General's report, I issued a memorandum on February 18, 1981 to senior departmental officials directing the following actions be taken:

- Each component head is taking immediate steps to insure that managers and supervisors are properly authorizing, certifying and documenting overtime. Further they are to evaluate a sufficient sample of their overtime usage across the country to determine that their supervisors and managers are in full compliance and will stay in full compliance, with governing policies and procedures;
- The Inspector General will conduct a follow-up audit of overtime control procedures after 90 days and report the findings directly to me;
- The Assistant Secretary for Personnel Administration is reviewing overtime policies and procedures for sufficiency with particular attention to internal payroll audit and control procedures, has increased the number of time cards audited each fiscal year, and in March 1981 completed the departmentwide distribution of the new timekeeper manual and self-training package.

The above actions are proceeding on schedule. I am confident that the directed measures will completely or greatly reduce those deficiencies found by the audit team. I intend to share with the committee the results of the second review by the Inspector General's office as soon as my staff receives his report.

FRAUD, ABUSE, AND WASTE

Question: We are pleased to note that the President is preparing a program to crack down on fraud, abuse, and waste on a broad scale. The President was to sign an Executive Order setting up a new Council on Integrity and Efficiency in government. Since HHS presumably will be represented on the Council, are you prepared to name a representative -- and who will it be?

Answer: President Reagan's Executive Order, signed on March 26, 1981, created the President's Council on Integrity and Efficiency. As stated in Section 1 of that Order, the Inspector General of HHS is the Department's representative on the Council. At this time, the President has not nominated anyone for that position.

Question: Is the $7 billion estimate of losses due to fraud, abuse, and waste still relevent? Is there a current estimate?

Answer: The $7 billion dollar figure represented estimated losses in FY 1977 and is generally out-of-date. However, the Department does not have a comparable estimate of current losses.

We believe the $7 billion is out-of-date because:

-- It was developed three years ago.

-- Two months after the Department's Inspector General released this figure, he revised the estimate downward to a range of $5.5 billion to $6.5 billion, based on new and more refined information. At that time the IG also classified these losses as follows:

- o Attackable under existing authorities ($2.7 billion)
- o Attackable with additional resources ($.5 billion)
- o Requiring new legislative authority ($1.2 billion)
- o Requiring further study ($1.1 to 2.1 billion)

Of the $2.7 billion classified as attackable under existing resources, the IG recognized that it would take time to reduce most of those losses.

-- In FY 79 the Department implemented a management savings program to document savings in those areas identified as attackable with existing authorities, as well as additional areas identified by the Department. Since FY 79, we have achieved specific documented savings, but have not yet conducted an analysis to determine how our efforts have impacted on the original estimate of losses. The Department documented savings of $1.4 billion in FY 79 and $1.2 billion to date in FY 80. Our FY 80 accomplishments are understated because of time lags in obtaining and analyzing data. We also believe the totals are very conservative because the Department only claims savings which it can document. As a result, we do not claim probable savings that result from the deterrent effects of our actions nor do we claim savings that we can not measure in some way.

The FY 82 budget request includes savings estimates of $2 billion in FY 81 and $3 billion in FY 82.

Concerning the losses classified as requiring further studies, the Department has undertaken a number of major initiatives, but we either have not completed studies or do not yet have systems in place to track and measure changes. For example:

-- Related to the estimated loss of $282 to $600 million due to unnecessary surgery, the Department implemented a public information program to promote the use of second opinions prior to consumers' deciding to have surgery and has sponsored four demonstration and evaluation programs in this area. Preliminary data indicate a positive cost/benefit ratio when a second opinion is sought. No conclusive data on the impact of specific changes are available at this time.

-- The Department is conducting studies to assist us in determining "acceptable error rates", i.e., at what level does the cost of reducing payment errors exceed the cost of the erroneous payments. The Department expects to complete the first study this fall. The Inspector General estimated potential losses in this category of $760 million.

-- In the area of unnecessary X-rays the Inspector General estimated losses of $432 million. The Department, in cooperation with the medical community (e.g., the American College of Radiology), is developing referral criteria for practitioners' use in determining whether an X-ray is medically indicated. The Department is also developing a nation-wide system to estimate the number of X-rays taken, by type, in hospitals. This system will allow us to evaluate trends, but will not allow us to determine the number of unnecessary X-rays or measure any reduction of dollar losses.

STATE CIVIL RIGHTS ROLE

Question: Departmental testimony last month indicated that the Office of Civil Rights is less than satisfied with the existing relationship between the Federal and State Offices for Civil Rights. What is being done to improve this relationship?

Answer: Generally the Office for Civil Rights works with the State program agencies in obtaining compliance when civil rights violations are found to exist. We do not recall having expressed dissatisfaction with State and local agencies.

Question: How will the roles of the Federal and State OCRs change with the proposed State or Federal offices and courts?

Answer: We do not anticipate any major change in the role of the Department's Office for Civil Rights or the role of the State program agencies in regard to civil rights enforcement.

PERSONNEL CUTS

Question: Has the Department planned any placement program for those people losing their jobs in a RIF? For example, would they get priority in filling the new positions which the Defense Department may get?

Answer: The Department will take the following steps to assist employees who must be separated.

Employees will be registered for the Displaced Employee Program managed by the Office of Personnel Management. Under this program employees will receive priority consideration for positions occurring throughout the Federal Government when these positions are filled from OPM registers. Employees will be able to register for consideration in one of ten regions and the Washington, D.C., metropolitan area.

In accordance with OPM regulations, the Department will establish reemployment priority lists in commuting areas where employees have been separated. Components of the Department will not be permitted to fill positions from outside if separated employees are available and qualified.

Beyond what the Displaced Employee Program requires, the Department cannot require that our employees receive priority consideration in the Defense Department and other agencies. However, we have already contacted officials of the Defense Department, the Veterans Administration and other agencies to explore placement opportunities. These agencies have been very receptive and have assured us that our employees will receive full consideration. The Defense Department is sending us copies of its vacancy announcements so that our employees will be aware of employment opportunities.

Within our Department, we will be requiring our components to publicize all vacancies so that employees who might be facing separation can apply and be considered. As stated above, in accordance with the reemployment priority list, positions will not be filled from the outside when there are separated Department employees available and qualified.

Our personnel offices will be establishing placement assistance programs. Each office will probably have a placement coordinator who will assist employees.

Within the Public Health Service where substantial reductions are expected, each vacancy is being carefully reviewed to determine whether any current employees might qualify. The National Institutes of Health has already made employment offers to 67 employees from organizations which are likely to be reduced. 42 of these offers were accepted.

Question: What are you doing to insure that the government is getting maximum work out of agency staff?

Answer: The Department's management-by-objectives (MBO) system provides one check to insure that units are working to maximize their output. The Department is currently monitoring 70 different initiatives and almost every major component within the various agencies is reporting certain aspects of its operations. A unit monitored under the MBO system develops quantifiable targets for what it expects to achieve during the fiscal year. These targets are reviewed to insure that goals will extend the unit (i.e., the unit will have to do things more efficiently in order to achieve the goals).

Quantifiable goals are also part of each manager's performance appraisal plan under HHS' implementation of the Civil Service Reform Act. When managers develop their plans, the plans are reviewed by supervisors to insure that satisfactory performance equates to achieving an appropriate level of output or handling a sufficient workload. To achieve a performance rating above satisfactory, managers must motivate their staffs to produce a higher level of output, handle a greater workload and/or handle a workload in a more timely manner.

Another method for insuring that we make the most use of our staff is the justification process for consulting services. One of the threshhold questions in that process is whether government employees, rather than contracted staff, should perform the work. The response to this question must go beyond establishing that the work is not a governmental function (e.g., work that is not policy/decision making or managerial in nature). It must establish that the work cannot be performed inhouse. The unavailability of staff (as opposed to the unavailability of technical expertise) is not a sufficient reason to contract. Offices can make staff available by shifting priorities, increasing workloads, combining projects, or determining other feasible ways to make the most efficient use of its resources.

An example of this process is the management control of certain contracts adopted by the Assistant Secretary for Management and Budget. In the FY 1980 internal review of some 100 consulting services contracts over $100,000, the Assistant Secretary either contingently approved or rejected about 55 percent. The reasons for contingencies or rejections included requiring staffing allocation and cost comparison studies to validate the continued need for contracted assistance and requiring offices to train government staff to perform contracted functions in the future.

Block Grants

Question: The States' overhead in program administration will necessarily increase with the advent of Block Grants.

Is there sufficient coverage for program support by the Federal Government to accomodate the phase-out or will states have to take up the slack?

Answer: The 1981 base amounts for block grant programs include about $91 million identified with administering existing categorical programs. Since about 75 percent of these funds will be turned over to the States, there will be a base established for State administration. In addition, the proposed block grant legislation gives the States flexibility in deciding how much to spend for administration. While we hope that these expenditures will be held to a minimum, we would recommend that the States program sufficient amounts in this area to assure appropriate stewardship of these programs.

Question: The introduction of block grants as proposed would consolidate the management of about 40 Federal health and social services programs into two administrative units.

What savings do you project in day to day management over the present system of agencies? How was this determined?

Answer: The total costs for the Federal government to administer the block grant programs are projected at $4.8 million in FY 1982 - $1.2 million per block grant.

We anticipate savings at the Federal level to total $75.2 million, the current cost of administering the categorical grant programs. This cost includes 2,439 full-time equivalent employees who manage the existing programs.

Health Promotion/Disease Prevention Block Grant Proposal

Question: Funds for the Block Grant in FY 1982 would be at 75% of current services level in FY 1981.

Would that figure be 75% of the FY '81 continuing resolution level or 75% of the revised 1981 level? Please explain how you determine the level of funding for the block grants in fiscal 1982.

Answer: The funding level for block grants was determined by taking 75 percent of the 1981 Continuing Resolution level; that is, the level of funding before any rescission proposals.

CAUSE FOR DEMOTION OR DISMISSAL

Question: What constitutes sufficient cause for demotion or dismissal?

Answer: In general, cause for demotion or removal rests on a violation of the employer-employee relationship in terms of conduct or performance. (We are not speaking here of demotions or removals resulting from reductions in force or other reasons not related to conduct or performance.) For employees covered by the procedural protections of Parts 752 and 432 of Office of Personnel Management Regulations, cause is more specifically defined as that which is necessary "to promote the efficiency of the service" or for "unacceptable performance," i.e., "performance of an employee which fails to meet established performance standards in one or more critical elements of such employee's position." A more detailed discussion of the phrase "to promote the efficiency of the service" and the "employer-employee relationship" is set forth in Chaper 752 of the Federal Personnel Manual. The meaning of sufficient cause is further refined on a continuing basis by appellate decisions of the Merit Systems Protection Board, the Equal Employment Opportunity Commission, the Courts, and statute. For example, 5 U.S.C. 2302 makes it unlawful to effect a demotion or removal action that discriminates for or against an employee "on the basis of conduct which does not adversely affect the performance of the employee," except conduct that involves conviction for a crime. (We understand that the Merit Systems Protection Board is currently reconsidering a number of cases involving this issue.)

DEMOTIONS OR DISMISSALS FOR WASTE OR FRAUD

Question: Has the Department demoted or dismissed any personnel for wasteful or fraudulent activities during the last year?

Answer: Yes. A survey of the headquarters offices of two of the Department's Principal Operating Components in Washington and Baltimore shows that approximately 3 dismissals, no demotions, and 10 suspensions without pay were effected in calendar year 1980 for wasteful or fraudulent activities. Time has not permitted us to survey the Department on a nationwide basis. However, we can do so, if you wish.

VOLUNTARY COST INCREASE GUIDELINES

Question: Why has this savings assumption been deleted from the Administration's estimates? Doesn't the Department think that such a voluntary effort would produce savings?

Answer: The Department has removed savings of $830 million attributed in the FY 1982 Carter Budget to the voluntary hospital guidelines because that program represented a burdensome regulatory approach. It is also unrealistic to expect the nation's hospitals to significantly curtail their expenditures in the absence of strong, competitive market pressures to do so. Accordingly, this Administration will introduce a pro-competitive legislative package that would reform the way health care services are paid for and delivered.

IMPACT OF INFLATION

Question: What is the effect of a one percent decrease in inflation rate of your budget?

Is there anything in the law that would result in a budget increase even if inflation were on the way down?

Answer: A decrease of one percent in the projected rate of inflation would reduce the cost of Medicare by about $500 million, Old Age, Survivors and Disability Insurance payments by about $1.4 billion and Supplemental Security Income payments by about $50 million.

Although inflation is certainly the major factor of increased spending in the HHS budget, there are other factors which, by law, would increase spending for entitlement programs. These factors include increased utilization rates under Medicare and Medicaid, increases in beneficiary population and higher unemployment.

SIZE OF BUDGET REDUCTIONS

Question: The budget submitted last January by President Carter requested $258.4 billion in budget authority for the Department of Health and Human Services. The revised budget submitted by President Reagan requests $255.3--a reduction of only $3.1 billion or about one percent from the Carter budget.

Given the magnitude of the cuts in other Departments and agencies, do you think the Department is shouldering its fair share with a cut of only one percent?

Answer: Actually, when you adjust the comparison of the 1982 Carter and Reagan budgets to take into account programs transferred to HHS from other Departments, including Community Services Adminstration and Rehabilitation Services programs, the reduction is about 3.5 percent.

I do believe that this Department took its fair share of the reductions. About 86 percent of 1982 HHS outlays are devoted to the Safety Net programs--those core programs which protect the elderly, poor and disabled.

As you know, President Reagan's 1982 budget is committed to preserving these social safety net programs. HHS programs outside the social safety net were, reduced about the same as other Departments.

MODEL STATE ADOPTION ACT

Last year on February 15, HHS published in the Federal Register a Model State Adoption Act. This model law was extremely controversial, and the Committee understands that over 8,000 comments were received on it.

Question: What is the status of this model act?

Answer: The Model Adoption Legislation and Procedures Advisory Panel, required by P.L. 95-266 was established in August 1978. It met nine times for a total of 27 days.

In October 1979, the Panel submitted its recommendations to the Secretary of HHS. The Secretary decided to publish the Panel's recommendations for public comment. In February 1980, the proposed Model State Adoption Act and Model State Adoption Procedures were published for a comment period of 120 days. During this comment period, the Department held ten regional meetings to elicit more extensive, in-depth, comments and discu-sion. Following this, the Department completed an analysis of the public comments, and identified several particularly conroversial issues. Consideration has been given to various options and the matter is currently under review by Secretary Schweiker.

Question: Does the Department intend to issue a final version of this act? Why?

Answer: Final version of the act will be issued as soon as the Department has taken into consideration various proposed options. The act will provide needed Federal leadership to improve the effectiveness of agencies and systems that will enable more children to be placed in adoptive homes without unnecessary delays.

SOCIAL SERVICES BLOCK GRANT

The idea behind the proposal to create a social services block grant is the desire to eliminate Federal administration and regulations, while allowing states great flexibility in choosing which services they might deliver.

Question: Would there be any requirement for states to report to HHS on the use they make of these funds?

Answer: States will be required to publish a document outlining proposed expenditures and make it available to State legislators and other interested parties. States will also be required to publish a year-end report outlining amount, purposes, and services for which funds were expended. While States are not required to submit expenditure reports to HHS, they will be made available to HHS upon request.

Question: When will the proposed block grant legislation reach the Hill?

Answer: Although the proposed block grant legislation is presently still in draft form and pending further review by the Secretary, HHS, the final document will be submitted to Congress within several weeks.

ADOPTION ASSISTANCE

The Administration is requesting a $5 million supplemental appropriation for adoption assistance, but is requesting no funds for this purpose in FY'82.

Question: Why is this supplemental being requested?

Answer: P.L. 96-272 established the Adoption Assistance program as an entitlement program for which States are entitled to receive funds. No funds were requested for 1981 and no funds are available for 1981 for this program. Therefore, because of the entitlement nature of the program, funds have been requested in a supplemental.

Question: How will this money be spent in FY 1981?

Answer: Funds provided by this program assist in paying maintenance costs for children who are adopted under certain conditions. Funds are also used to pay for the administrative costs of managing the program and for training the staff. Because this is a new program and the ability of States to take advantage of the funds for a full-year is limited, the FY 1981 request is a partial year request to support an average monthly caseload of 2,000 children.

AGING "BLOCK GRANTS"

The last time the Older Americans Act was revised, Congress mandated a separate home-delivered meals program, to correct the fact that local nutrition project sponsors were giving inadequate attention to the needs of the home-bound elderly.

Question: What protections will be included in your block grant proposal to assure an adequate level of home-delivered meals to shut-ins?

Answer: States will be given the flexibility to provide those services that they believe are best responsive to the needs of their population. However, for the first year under the new legislation, States would be required to maintain the same total dollar level for nutrition services as the State had for nutrition in FY 1981. I would assume that effective programs would be continued even beyond the one-year hold-harmless where they are needed.

SOCIAL SERVICES DISCRETIONARY ACTIVITIES

There is a new activity in the Office of Human Development Services for social services discretionary activities. This new activity would fund research and demonstration projects in many areas of social services delivery, management and development. (The budget requests $60.75 million for this purpose).

Question: How would priorities be chosen for this research money?

Answer: The Office of Human Development Services is in the process of developing the 1982-1983 research and demonstration strategy. This will involve intensive consultation with States. The priorities will be in areas such as those that:

- address issues that cut across States,
- support State and local administrative and management responsibilities for social services,
- fill knowledge and information gaps, and;
- transfer knowledge about delivery systems, tools, and information to States to improve current services delivery.

Question: How was this budget level picked? Why not $50 million? Or $70 million?

Answer: The FY 1982 Budget Request, includes reductions that are a part of the President's economic recovery plan. This reduction is one of those. Service activities have been reduced by approximately 25% and likewise, these discretionary funds are approximately 25% less than in 1981.

Question: For the record, provide a breakdown of how much money would be spent for which purposes in FY'82 with this budget request?

Answer: It is hard to say at this point exactly how much will go to each category of research or demonstration activity. However, there will continue to be some activity in each of the categorical areas that have been consolidated. Projects will be reviewed carefully to determine whether or not they support the priority activities as outlined earlier.

SUBCOMMITTEE RECESS

Senator SCHMITT. I want to thank you personally, Mr. Secretary, for returning for this extra session. Your entire testimony has been very helpful. I appreciate the style and grace with which it was conducted. You and your staff are to be complimented for your preparation.

This afternoon's hearing concludes the subcommittee's regularly scheduled hearings on the fiscal years 1981 and 1982 budget as now submitted by the Reagan administration.

The subcommittee will stand in recess subject to the call of the Chair as we prepare for markup.

[Whereupon, at 4:55 p.m., Wednesday, April 8, the subcommittee was recessed, to reconvene at the call of the Chair.]

[CLERK'S NOTE.—The July 20, 1981 testimony on the administration's request for the Public Health Service hospitals follows.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1982

MONDAY, JULY 20, 1981

U.S. Senate,
Subcommittee of the Committee on Appropriations,
Washington, D.C.

The subcommittee met at 2:25 p.m., in room 1114, of the Everett McKinley Dirksen Senate Office Building, Hon. Harrison Schmitt (chairman) presiding.

Present: Senators Schmitt, Andrews, and Rudman.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DR. EDWARD BRANDT, ASSISTANT SECRETARY FOR HEALTH

ACCOMPANIED BY:

MS. ALAIR A. TOWNSEND, DEPUTY ASSISTANT SECRETARY, HEALTH OPERATIONS

JOHN KELSO, ACTING ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION

JOHN MAHONEY, CHIEF, BUDGET BRANCH, PUBLIC HEALTH SERVICE

ANTHONY ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET

ROBERT PELLICCI, BUDGET OFFICER, HEALTH SERVICES ADMINISTRATION

SUBCOMMITTEE PROCEDURE

Senator Schmitt. The hearing will come to order. I apologize to my colleagues for the delay.

Today we shall take testimony on the administration's request for a $16.8 million supplemental appropriation for Public Health Service hospitals. Less than 2 months ago, Congress provided the Department of Health and Human Services with a $40 million supplemental to facilitate its plan to shut down the eight PHS hospitals this year and, as I recall, to make it possible through that supplemental for local entities to assume that service if they desire to do so.

Now we're being told this isn't enough, $16.8 million more will be necessary for that purpose in this fiscal year because of unanticipated losses in revenue, I presume because of anticipation of the loss of service in these hospitals. But that is one reason we are here today, to discover why this miscalculation occurred.

Here to testify in support of the administration's request is Dr. Edward Brandt, Assistant Secretary for Health, who is making his first appearance before this subcommittee.

But before we go ahead, Doctor, we will hear from several Members of the Senate on this matter, and then we will go into the basic Department rationale for the supplemental request. We have with us today Senator Jackson from Washington, Senator Sarbanes of Maryland, and as I understand it, Senator Gorton would like to join us also, and, I presume, is on his way.

Senator Jackson, as senior member, would you please proceed.

STATEMENT OF HON. HENRY M. JACKSON, U.S. SENATOR FROM WASHINGTON

Senator JACKSON. Thank you, Mr. Chairman. I want to compliment you and thank you and the committee for the expeditious way in which you have moved on the President's supplemental request for funds for the Public Health Service.

I would ask that my statement be put in the record, and I shall try to give you a quick synopsis.

Senator SCHMITT. Without objection, it will be in the record.

[The statement follows:]

STATEMENT OF SENATOR HENRY M. JACKSON

I want first to commend Senator Schmitt on this quick action in holding this hearing on the administration's request for an emergency supplemental of $16.8 million for the continued operation of the Public Health Service hospitals through fiscal year 1981. The Congress received very short notice of this lack of funds, and it is essential now that we act quickly. Congressman Natcher held hearings last Friday before the Labor/HHS Subcommittee of the House Appropriations Committee. They also completed markup out of subcommittee. We need to be as efficient here in the Senate.

When I first learned of this lack of funds, it occurred to me that the way to handle this miscalculation was through reprograming. While there has been much discussion with regard to this during the last few days, the administration appears to be standing firm against that route. I would find that stance unwarranted and would press further for the administration to reconsider. Barring that, Congress must take the responsibility and act favorably on this supplemental.

I have long been concerned for the future of the Public Health Service hospitals, particularly Seattle's, since the facilities were threatened with closure in the early 1970's. The Seattle PHS Hospital has increasingly focused its resources on the unmet needs of the Pacific Northwest and is an integral element of the medical system in this region. I simply do not agree with the administration's policy to close these hospitals.

I believe that by objective standards the Seattle hospital is one of the finest, most cost-effective hospitals within our public health care system. It is of vital importance to the delivery of health care in the Northwest. Over 50,000 people in the Northwest depend on the PHS hospital for the delivery of health care. The traditional beneficiaries of the PHS hospital include seamen, fishermen, defense, and other Federal personnel, retirees, dependents, and native Americans. The Seattle private sector cannot absorb this number. Regardless of the outcome of the PHS system, the Federal Government will continue to be obligated to provide health care to many, if not all, of these groups.

The Mayor of Seattle, at the request of several members of the Washington State delegation, convened a task force in February that included representatives of patient groups, private medicine, State and local governments, health care planning agencies, and other interested groups to examine the options in the event the hospital were closed. The task force has made much progress toward the establishment of a city-chartered public authority to operate the hospital. All this was done in reliance on the administration's assurances that it would aid the communities in their efforts to take over its facility. The Congress also addressed the issue of Federal assistance to communities wishing to take over their facility. The conference language—H.R. 97-124—of the President's rescission package gives priority for allocating fiscal year 1981 funds to those hospitals "whose communities have made a firm commitment to assume their operation * * *" Without this supplemental request, the task force's efforts, as well as those efforts made in other communities, will have been meaningless. No community can be expected to take over their hospital prior to the end of fiscal year 1981; never was there that expectation. Both the administration and the Congress have made commitments which necessitate the passage of this supplemental.

There was much support shown by my colleagues here in the Senate as we worked through the fiscal year 1981 supplemental measure. Senator Stevens, in particular, continues to be willing to do what he can to be of help.

What we need is the $16.8 million to get us through to October 1, 1981. I believe the investment would represent substantial savings to the Federal Government in the future by adding the necessary time for the now-Federal institutions to be turned into local entities capable of serving Federal beneficiaries at a lower cost than would otherwise be possible. The need is realistic. And the transition needs to be consistent with the assurances of the administration to try to ease the way for the creation of a viable new entity.

This $16.8 million needed to achieve the fiscal year 1981 transition is well within the realm of possibility and well within the contemplation of both the administration and Congress as they both dealt with the possibility of local control.

The Seattle hospital is a nationally recognized facility supporting a remarkable network of primary care facilities in Seattle and throughout the region. The critical role it plays in our area's health care system has led Governor Spellman and Seattle Mayor Royer to advise Secretary Schweiker that they intend to pursue local control of the facility.

I hope that the subcommittee will agree that the best and long-term interests of the Federal Government would not be served simply by locking the doors of facilities whose communities have gone far down the road toward takeover. That is the alternative to this supplemental budget request. Such an action would prove penny wise and pound foolish in terms of providing care to Federal beneficiaries, let alone our continued obligation to others in the population who depend upon that fine hospital and its dedicated staff and who literally have no alternatives.

TRANSITION PERIOD

Senator JACKSON. As the committee knows, the funds are requested for the purpose of taking care of the employees through September 30. As the chairman mentioned, the Public Health Service ran into some unanticipated losses related to, but not entirely, to the funds that they had expected to receive but which they did not receive. Obviously, a number of cases were taken away from the Public Health Service, assuming that they were not going to operate after October 1.

In support of the funds, may I just say that it is necessary in order to achieve the transition which we out in Seattle are very hopeful of achieving. Senator Gorton and I have been working closely with the city government, where they have put together a plan to take over the hospital and operate it, assuming a lot of things, which includes that there will be clientele from the Federal Government, people with entitlements, if they are military, active-duty personnel or dependents of military, including, of course, the people in the merchant marine service that are entitled to that support under existing law, and a very large Alaska Native population, as well as our own Indians in the State of Washington.

Fundamentally, what is needed, Mr. Chairman, is a breather here, so that the city will have an opportunity to come forth with their final plan, which I understand they will be able to do, as they represented to Senator Gorton and me, that they will have a plan that will work.

Very candidly, there are a lot of other things that remain to be done. Basically, it relates to capital improvements that will be required for the hospital in Seattle. The hospital does not now meet the earthquake standards of existing local ordinance and Federal requirements. So there will be a need to take care of those capital requirements.

And I think there will have to be, obviously, some transition funds in the fiscal year 1982 budget to carry over long enough for the city plan to be implemented. That's basically, I think, the situation that we face at the moment.

Senator SCHMITT. Thank you, Senator.

Senator Sarbanes, if you will allow me, since we're discussing specifically now the Seattle situation, I would like to ask Senator Gorton to provide his comments.

STATEMENT OF HON. SLADE GORTON, U.S. SENATOR FROM WASHINGTON

PREPARED STATEMENT

Senator GORTON. Mr. Chairman and members of the subcommittee, I too want to thank you for your extremely prompt attention to this request from the President, because of its significant impact on the Public Health Service hospital in Seattle.

Mr. Chairman, I would ask that you include the balance of my written statement in the record.

Senator SCHMITT. Without objection, it will be included.

[The statement follows:]

Mr. Chairman, members of the subcommittee, I want to thank you for your prompt consideration of the emergency supplemental request of the Department of Health and Human Services. Swift action on this request is not only necessary to assure the continued efforts of the affected communities to develop plans for assuming control of the hospitals but is vitally important to the employees of the hospitals and certainly to the patients.

While it is unfortunate that this supplemental request is necessary, particularly since we have just finished with the supplemental appropriations and rescissions bill, we should not let the circumstances under which the request has arisen cloud our consideration of its merits. In the course of the supplemental appropriations and budget processes, the Congress has shown its clear intent that, if the Public Health Service hospitals are to be closed, the communities in which they are located are to be given the opportunity to assume the operation and control of the facilities.

In Seattle, the Public Health Service hospital plays a key role in providing both health care and as a teaching and research facility. It is estimated that the Seattle area will have a shortage of more than 400 hospital beds by 1985 even without the closure of the Public Health Service hospital. There can be no doubt that the closure of the hospital will have a devastating impact on the delivery of health services in the Seattle area, as well as aggravating the area's unemployment problem.

Because of this, the Washington State delegation, the city of Seattle, the State, and many other interested parties have spent numerous hours and great efforts to develop a plan for the assumption of control of the hospital by the community. That plan has already been submitted to the Secretary of HHS as have the plans of several other communities. We are hoping to be able to work with the Department in the coming months to perfect the plan. If this supplemental request is rejected, there can be no community takeovers and the good faith efforts of citizens around the country will have gone for naught.

I urge you to support the promise Congress has made to these communities. We owe them a reasonable chance to salvage what, in many instances, is a medical resource that cannot be replaced.

BACKGROUND

Senator GORTON. I will not read that statement.

Perhaps a little bit of background on this entire issue is in order, as Senator Jackson and I and Senator Sarbanes have been dealing with it for some months now, and it has not, of course, been at the forefront of your own consideration.

The President, at the time of his initial budget submission, asked for the termination of the statutory merchant marine health care entitlement program and the closure of eight Public Health Service hospitals across the United States. He did, however, recognize that in some cases those hospitals were vital parts of the health care system of the communities in which they existed and, therefore, called for appropriate transition measures which would permit the transfer of Public Health Service hospitals into community control and called for a closure of the hospitals no earlier than the end of fiscal 1981.

As a consequence, the Budget Committee in its original reconciliation proposal, as well as in the first budget resolution, has provided for transition to community control of certain hospitals which come up with acceptable community plans. This implies not only the continuation of those hospitals meeting those prerequisites through fiscal 1981 but transition funds through fiscal 1982 as well.

Both the House and the Senate versions of the budget proposal which is now in conference reflect that policy and do have provisions for both the provision and the acceptance of community transfer plans.

The Seattle community has done a particularly outstanding job, because of the importance of the hospital in the community, in coming up with such a plan, which is before the Department of Health and Human Services at the present time in a highly detailed fashion, and which does call for the takeover of the Public Health Service hospital and its continuance in operation under community control, with fiscal year 1982 being their transition period.

It was expected by everyone, including the Department of Health and Human Services and OMB, that there was, obviously, enough money in the present budget to continue these hospitals in being through the end of this fiscal year. And the rescission bill which we passed just a few months ago included that as an assumption.

What has happened has been that various projections evidently were seriously in error, so that the supplemental appropriation which is before you now is simply to continue these hospitals in existence through the end of this fiscal year. Several of them, perhaps half of them, will still be closed on September 30, 1981, because there will not be any submission of community plans for them. But if those, which include not only the Seattle hospital but the Baltimore hospital, in which there is a very high degree of prospect for success in the community plans do not get enough money to cover this August 15 through September 30 period, those community plans will, of course, be destroyed; a tremendous amount of effort on the part of the communities will have gone for naught, and the promise of the administration to allow for that community takeover will not, in fact, be the case.

I am convinced that it is for exactly that reason, that the administration does propose to keep its promises, that you have a rather extraordinary request before you here, one which was approved not only by the Department but by OMB and the President as well. And in that respect, I join with my colleague Senator Jackson, with whom I have worked very, very closely in connection with our own Seattle facility, in asking for very prompt consideration of this proposal.

Obviously, if we haven't completed action on it by the time we take our August recess, it is the same as saying, "No, the promise will not be kept."

Senator SCHMITT. Senator Sarbanes.

STATEMENT OF HON. PAUL S. SARBANES, U.S. SENATOR FROM MARYLAND

Senator SARBANES. Thank you, Mr. Chairman. I want to join my colleagues in commending you and the subcommittee for promptly addressing this question.

I think it's imperative that the additional funds be supplied in order to keep the Public Health Service hospitals and clinics in operation through the balance of this fiscal year. The urgency of the request before you rests on the fact that several communities have been preparing to take over these hospitals and have made elaborate plans in order to do so.

Mr. Chairman, I will submit my full statement for the record, and just summarize it very quickly.

Senator SCHMITT. Without objection, it will be included in the record.

[The statement follows:]

STATEMENT OF SENATOR PAUL S. SARBANES

I appreciate the opportunity to appear today to express to the members of the subcommittee my support for the expeditious consideration and approval of the fiscal year 1981 emergency supplemental request for the Public Health Service hospitals and clinics system. The urgency of the supplemental request of $16.8 million to enable the PHS hospitals and clinics to operate for the balance of fiscal year 1981 rests on the fact that several communities have been preparing to take over the PHS hospitals in their area. Lack of funds to operate the PHS hospitals for the balance of the current fiscal year would thwart those plans, furlough 4,000 employees, and literally destroy the PHS hospitals as an important community health resource.

Failure to provide the operating funds would have a severe impact on the Baltimore PHS Hospital and the people it serves. The hospital currently provides acute inpatient medical, surgical, psychiatric, and alcoholism services, a wide range of specialty and ancillary services, as well as several special programs such as a geriatric day treatment center, community geriatric service, psychiatric day hospital, and the center for occupational and environmental health. Many of the Baltimore hospital's services are provided jointly with such community and academic-based agencies and institutions as the North Baltimore Community Mental Health Center, the North Central Baltimore Health Corp.—which since 1978 has run the Hampden, Woodberry, Remington Community Health Center—and the Johns Hopkins University School of Medicine and School of Hygiene and Public Health. These institutions and services are particularly important to the 50,000 residents of neighborhoods near the hospital designated as a medically underserved area, as well as to the primary beneficiaries.

Since the announcement by the administration of its intent to terminate the PHS hospital system, the patient advisory group for the Baltimore hospital began to plan for the hospital to be taken over by a local, nonprofit organization, the Wyman Park Health System—WPHS. The conversion proposal, submitted to Secretary Schweiker, was prepared in conjunction with the Johns Hopkins University, the North Baltimore Center, the North Central Baltimore Health Corp., and the city of Baltimore. Also joining the effort are many civic and community associations; and the Governor of Maryland, Honorable Harry R. Hughes, has expressed his strong support.

In utilizing the Baltimore PHS Hospital, it is the goal of the WPHS to maintain the fine medical care which is currently provided to merchant seamen, Coast Guard, Department of Defense, and NOAA personnel, PHS officers, and the central Baltimore city communities. The Baltimore PHS Hospital has a highly regarded staff of great dedication and enjoys broad community support and use. The WPHS will draw on these strengths to provide accessible, high-quality comprehensive health care while assuring continuity of the staff, services, and care now delivered to its patients. The hospital will also serve as a center for medical training and research with a close affiliation with the Johns Hopkins University. Its extended system of community health and mental health centers will be retained and expanded focusing on primary ambulatory care, preventive and therapeutic medicine, and health and social services.

It will be impossible to carry out this goal if the present staff of the Baltimore PHS Hospital is furloughed because of lack of operating funds for August and September. Already, the impact of the administration's plan for the PHS hospital system has caused attrition in staff, particularly in new PHS doctors. The Baltimore PHS Hospital presently employs over 600 people; and the great fear is that these employees, if furloughed, will obtain other jobs and be lost to the hospital. Continuity of the staff is absolutely critical to the well thought-out conversion plan, so widely supported by the community, Baltimore city, and the State. Termination of the operating funds before the end of the fiscal year also runs counter to the conversion process outlined in both the Senate and House versions of the reconciliation measure. It is therefore vital to this effort that the supplemental request be approved; and I urge the subcommittee to act promptly.

TRANSITION PERIOD

Senator SARBANES. Since the announcement by the administration of its intent to terminate the hospital system and, of course, the action in both Houses providing the transition period—that is now being resolved in conference with respect to the reconciliation. But the judgment in both Houses was that it would go into the next fiscal year—there is some difference as to how far into the next fiscal year—in order for this transition to be accomplished.

In Baltimore, a patient advisory group for the Baltimore hospital has planned for the hospital to be taken over by a local nonprofit organization. A conversion proposal has been submitted to Secretary Schweiker on July 1 of this year. That was prepared in conjunction with the Johns Hopkins University, one of the world's foremost medical institutions, and a number of local health corporations. And both the city and State are in very strong support.

It would be impossible to achieve this resolution of the problem, one which the administration indicated it very much sought and one which the Congress has, in effect, endorsed, if the present staff is furloughed because of a lack of operating funds for August and September. In fact, the danger of that is obviously causing some attrition already and therefore already raising a serious problem. And continuity of that staff is critical to a well thought-out conversion plan, which is so widely supported in our community and by the city and by the State.

Now, there are a number of communities which, faced with this challenge—and many of us differed with the fundamental decision, but it was put forward by the administration and, in the end, accepted by a majority of the Congress. There are many communities which, in the face of this fundamental challenge, have accepted it and gone out to do what they were asked to do. That is, to find a way, if possible, and if it served a real community need, to shift it over to community operation and community control.

Seattle is one such community. And I understand that hospital has corroborated its ability to acquire sufficient revenue and to charge competitive rates using a financial-feasibility model developed by Arthur Anderson. And the Baltimore hospital is now making use of the same model with respect to its projections and has been able to reach the same conclusion in terms of prospective financial feasibility.

We very desperately need this request to design and provide the additional funds to continue the operation through this fiscal year, and then the transition aspect of the next budget, which is now being resolved in conference, to enable us to complete a well thought-out conversion plan, to hold together the hospital staff as a functioning unit. And I think if we can obtain that, there is a very high likelihood that we will be able to keep this facility functioning, providing a very important community service and very important medical services to the beneficiary classes which the Public Health hospital has traditionally served.

We are very proud of our institution. We think it does fine work in Baltimore. It's got an excellent staff with a very high morale. And we need this chance to accomplish the transition so that the institution can continue to function.

I would very much hope that the committee would agree with that perspective and reach a favorable judgment in this matter.

Senator SCHMITT. Thank you, Senator.

Senator Rudman, did you wish to make a statement?

Senator RUDMAN. No statement at this point.

Senator SCHMITT. Let me ask a couple of background questions.

Senator Sarbanes, it is my understanding that the anticipated transition funding for the Baltimore hospital for fiscal year 1982 will be $26.5 million, and for fiscal year 1983, $4.5 million. Are those figures consistent with your information?

Senator SARBANES. Those figures appear to coincide with the ones that I have before me, Mr. Chairman, in the proposal.

Senator SCHMITT. It is my understanding, for the Seattle hospital for fiscal year 1982, the transition cost will be $56.5 million.

Senators, you or the Department may wish to revise these figures, if you do, we would be happy to receive them. However, I am including in the record the figures that we have before us today.

For 1983 it would be $2,725,000; and 1984 it would be $233,000, what HHS calls a subsidy and I think you would probably call transition funds.

Senator GORTON. That initial figure for next year is too high and combines two separable items: the amount required for capital improvements to bring it up to the codes which Senator Jackson referred to, and a considerably lesser amount for operations and maintenance.

Senator JACKSON. Mr. Chairman, my understanding was that it's $34 million in connection with the construction requirements, rehabilitation requirements to bring it up to code, and $4 million for operating costs, or a total of $38 million in fiscal year 1982. And then I don't have the immediate figure for——

Senator SCHMITT. We'll make sure we know those. I just wanted to make it clear that, generally, there will be some additional phaseout Federal costs if we——

Senator GORTON. There's no question about that, Mr. Chairman. It was to that that I referred. That is reflected in the first budget resolution in both versions before the conference committee.

Senator SARBANES. Mr. Chairman, on the Baltimore facility, in the proposal submitted to Secretary Schweiker, the local group indicated they were prepared to assume operation of the Baltimore Public Health hospital by November 1, with appropriate governance, organizational management systems in place. However, they will not be able to get the State licensure and the certificate of need and the reimbursement rates fully approved by that period of time. And they need some time to meet that, and they need some support.

Two-thirds of the moneys that you mentioned that the Baltimore hospital had indicated are necessary are in the capital area. We have this situation of the necessity to make capital improvements, the need for some working capital. And that, added together, is just under $20 million of the approximately $30 million, $31 million, that the figures you gave would add up to. The balance was some operating money in fiscal 1982 and some training and research money.

But this is a well thought-out plan. It has involved a tremendous degree of community involvement. There's some really first-class people involved, and there's a linkage with the Johns Hopkins University, which lends the resources of that really extraordinary medical institution to the support of this hospital.

We have a chance, if it just can be realized, of accomplishing something that I think any objective observer would regard as a very constructive response.

Senator SCHMITT. It is my impression that both the Baltimore and the Seattle communities have really done very well in trying to put together a workable transition plan.

Senator JACKSON. Mr. Chairman, we also have a linkage with the University of Washington medical school, one of the great medical schools. [Laughter.]

Senator SCHMITT. I was afraid that wouldn't come out in the testimony.

Senator JACKSON. Well, we were holding back. [Laughter.]

Senator SCHMITT. I understand there has been a lawsuit filed against Secretary Schweiker by the Seattle public and private officials in connection with this. Senator Jackson or Senator Gorton, do you understand the basis for this suit?

I think it was just filed, what, last week, late last week?

Senator GORTON. That's correct. I have a copy of the pleadings here, Mr. Chairman. It was filed, but they have not sought a TRO, pending the outcome of activities here in the House and the Senate.

Senator SCHMITT. So the lawsuit is filed in anticipation of the possibility that there might not be any supplemental?

Senator GORTON. That's correct.

Senator JACKSON. We had nothing to do with it. It was an entirely independent action.

Senator GORTON. That is true.

Senator JACKSON. I just heard about it after the filing.

Senator SCHMITT. You wouldn't think this was undue pressure on the Senate subcommittee.

Senator JACKSON. I think it's a normal response given the set of facts. [Laughter.]

But in conclusion, Mr. Chairman, I would just like to point out that this, in my memory, is a rare request, because the administration, sending up a supplemental, usually waits for several other items of an urgent nature. But this supplemental addresses only the issue that we are discussing here today. As I understand it, there are no other requests accompanying that supplemental.

Senator SCHMITT. No, there are not.

Senator JACKSON. To point up the urgency of it.

Senator SCHMITT. The thing that confuses me about this is that a reprograming would have been much quicker. Do any of you have an objection to a reprograming if it looked like that was the best strategy and fastest way to provide the $16 million?

Senator GORTON. Speaking for Senator Jackson and myself, certainly none whatsoever. Our goal, of course, is to see to it that we are permitted to continue in operation through October 1.

When I was informed of this action by Secretary Schweiker, he simply stated that reprogramings were impossible. That was the first subject which we brought up with him. The potentials fell into exactly the categories which you have here before you in a particular chart.

We have no position on that one way or another. We simply want the job accomplished. If it can be done by reprograming, that's perfectly appropriate.

Senator JACKSON. That is the fastest way to do it.

Senator SARBANES. Mr. Chairman, I think it's important to get the money there, and as quickly as possible. The timing is very important, because, you know, you are losing staff that you ought not to lose, and you lose the good people, because they're the ones who, obviously, can claim job opportunities elsewhere in this field. And when you have a unit that's been put together and has worked well, you don't want to lose them while you're trying to accomplish this transition.

I must say to you, I know a little bit about the Seattle situation. Of course, I know the Baltimore situation very well, also. And without addressing the situation elsewhere, I do know that in these two communities, there has been a tremendous response to the challenge that was put to them, in effect, after an initial reaction of saying this shouldn't be done at all. But we're beyond that point.

People have gone out and worked very hard. They've worked very hard to put this together. A lot of quality institutions and individuals have involved themselves, and they've come up with a solution which makes enormous good sense. And to sort of lose it or let it slip away, I think it would be a cause of regret on the part of all of us.

Senator GORTON. I think it's safe to say that the fact that the three of us are here is simply another indication that Seattle and Baltimore are closer to having reached this decision than others are, although there are some of the other hospitals in which there's some chance of such community plans succeeding.

Senator SCHMITT. I think, generally, my impression is the subcommittee as well as the full committee members are with you in spirit. We're just a little bit surprised as to why a supplemental was requested and not a reprograming. And we have not been able to get an answer to that.

As much as I respect our former colleague's opinions, I am not yet sure why it is impossible for us to do it the faster way and more certain way at this time. And that's a reprograming. So we will be looking at both possibilities.

Senator Rudman, do you have any questions?

Senator RUDMAN. Thank you, no.

Senator SCHMITT. Thank you, gentlemen.

Secretary Brandt, Dr. Brandt, if you will come forward with whatever staff you wish to have accompanying you, and introduce them for our record.

INTRODUCTION OF ASSOCIATES

Dr. BRANDT. Thank you very much, Mr. Chairman. Let me introduce those that are here with me.

To my left is Alair Townsend, Deputy Assistant Secretary for Health Operations and Director of the Office of Management for Public Health Service. Sitting next to me, Mr. John Mahoney, Chief of the Budget Branch of Public Health Service. To my right, Mr. John Kelso, who is the Acting Administrator of the Health Services Administration. Next to him, Mr. Robert Pellicci, Budget Officer of the Health Services Administration. To my far right, Mr. Anthony Itteilag, who is the Acting Deputy Assistant Secretary for Budget Affairs.

I would ask that my statement be included in the record.

Senator SCHMITT. Without objection, it will be included in the record.

[The statement follows:]

STATEMENT OF DR. EDWARD BRANDT

I appreciate this opportunity to appear before you to discuss our fiscal year 1981 emergency supplemental request for the Public Health Service hospitals and clinics system. I wish to begin by conveying to you, Mr. Chairman, and the other members of this committee, the urgency with which the administration is proposing this supplemental request. The Congress has directed the Department to keep the hospitals open until October 1, 1981, and to pursue actively and effectively the transfer of hospitals for community use. We share these goals and wish to comply. However, because of the shortage of funds, neither goal can be achieved. The $16.8 million which we are requesting is critical in order for the PHS hospital and clinics to continue operating for the remainder of fiscal year 1981. Unless these funds are appropriated, it will be necessary for the 8 general medical-surgical hospitals and 27 outpatient clinics to close in August of this year. Operations would continue at the National Hansen's Disease Center in Carville, La., for the full fiscal year.

I am before you today requesting your expedited approval of the emergency supplemental, cognizant of the short timeframe which is being provided Congress to consider this request, and grateful for your committee's prompt hearing.

Earlier in the year, rising hospital costs necessitated a series of management actions to operate within budget levels. It was projected that these actions, coupled with congressional approval of the President's revised 1981 budget, would provide sufficient funds to accomplish an orderly phasedown of hospital operations.

However, Mr. Chairman, several subsequent events have resulted in a funding shortage:

First, and most significant, is our recent projection of revenues which indicates that we will have a $12.5 million shortfall in reimbursements from patients served by the system. These patients, DOD patients and others, have not utilized the system in the numbers which had been projected earlier. Hence, the level of services rendered and the moneys collected as a result have declined.

Second, on June 4, 1981, the U.S. District Court ordered the Department to continue the provision of contract medical care and to maintain PHS hospital and outpatient clinic operations at the 1973 level as required by Public Law 93-155 without regard to current budget restraints.

While the order was vacated by the appellate court on June 25, 1981, compliance with the order during the effective period is estimated to have cost $1.7 million.

Third, the 1981 Supplemental Appropriations and Rescissions Act increased the rescission for the hospitals and clinics by $1.1 million above the President's request.

Fourth, this same act established a funding limitation of $128.4 million for hospitals and clinics operations. This limitation precluded the administration from requesting a $1.5 million reprograming request from building and facilities funds needed to assist the PHS hospitals and clincis in their efforts for an orderly phaseout.

These factors, in total, have produced a $16.8 million operating deficiency. Without these funds the administration will be forced to terminate inpatient care by August 1, 1981, and outpatient services would cease on September 1, 1981. In addition, over 4,000 civil service and wage grade employees would have to be furloughed, and would not receive any severance pay or lump-sum leave pay until next fiscal year when funds become available.

While unemployment compensation may be applicable in some cases during the furlough period, benefits have to be determined by the local unemployment office.

Early closure of the hospitals and clinics is not consistent with the President's plan and congressional intent, and would also seriously jeopardize community takeover of these facilities. Such community takeover is an important element of the President's proposal for the closure of the PHS hospitals and clinics system.

I hope, Mr. Chairman, that I have been able to convey the urgency of this need.

At this time, my staff and I will be happy to answer any questions which you and the committee might have.

EMERGENCY SUPPLEMENTAL REQUEST

Dr. Brandt. I appreciate very much the opportunity to appear before you and your committee this afternoon to discuss our fiscal year 1981 emergency supplemental request for the Public Health Service hospitals and clinics system. I wish to begin by conveying to you, Mr. Chairman and the other members of this committee, the urgency with which the administration is proposing the supplemental request.

The Congress has directed the Department to keep the hospitals open until October 1, 1981, and to pursue actively and effectively the transfer of hospitals for community use. We share these goals and wish to comply. However, because of the shortage of funds, neither goal can be achieved.

The $16.8 million which we are requesting is critical in order for the PHS hospitals and clinics to continue operating for the remainder of fiscal year 1981. Unless these funds are appropriated, it will be necessary for the 8 general medical-surgical hospitals and 27 outpatient clinics to close in August of this year. Operations would continue at the National Hansen's Disease Center in Carville, La., for the full fiscal year.

I am before you today requesting your expedited approval of the emergency supplemental, cognizant of the short timeframe which is being provided Congress to consider this request and grateful for your committee's prompt hearing.

Earlier in the year, rising hospital costs necessitated a series of management actions to operate within budget levels. It was projected that these actions, coupled with congressional approval of the President's revised 1981 budget, would provide sufficient funds to accomplish an orderly phasedown of hospital operations. However, several subsequent events have resulted in a funding shortage.

First, and most significant, is our recent projection of revenues, which indicates that we will have a $12.5 million shortfall in reimbursements from patients served by the system. I should point out, the first month in which that occurred was the month of May. We are now projecting a much more significant drop in June and an even more significant reduction in July.

These patients, principally Department of Defense patients but also others, have not utilized the system in the numbers which had been projected earlier. Hence, the level of services rendered and the moneys collected as a result have declined.

Second, on June 4, 1981, the U.S. District Court ordered the Department to continue the provision of contract medical care and to maintain PHS hospital an outpatient clinic operations at the 1973 level as required by Public Law 93–155 without regard to current budget restraints. While the order was vacated by the appellate court on June 25, 1981, compliance with the order during that period is estimated to have cost $1.7 million.

Third, the 1981 Supplemental Appropriations and Rescissions Act increased the rescission for the hospitals and clinics by $1.1 million above the President's request.

Fourth, this same act established a funding limitation of $128.4 million for hospitals and clinics operations. This limitation precluded the administration from requesting a $1.5 million reprograming request from building and facilities funds needed to assist the PHS hospitals and clinics in their efforts for an orderly phaseout.

These factors, in total, have produced a $16.8 million operating deficiency. Without these funds, the administration will be forced to terminate inpatient care by August 1, 1981, and outpatient services would cease on September 1, 1981. In addition, over 4,000 civil service and wage-grade employees would have to be furloughed and would not receive any severance pay or lump-sum leave pay until next fiscal year when funds become available. While unemployment compensation may be applicable in some cases during the furlough period, benefits have to be determined by the local unemployment office.

Early closure of the hospitals and clinics is not consistent with the President's plan and congressional intent and would also seriously jeopardize community takeover of these facilities. Such community takeover is an important element of the President's proposal for the closure of the PHS hospitals and clinics system.

In response to earlier discussion, Mr. Chairman, the Secretary and I have examined a number of funding alternatives before recommending a supplemental appropriation to you. These options include a reprograming of funds from the relatively small grant programs administered by my office. I do not recommend this approach for several reasons.

First, most of these funds support continuation of existing projects, and only $3.3 million is for new awards. In other words, $15.5 million would have to be taken from noncompetitive projects, most of which would be funded through the block-grant mechanism in fiscal year

1982. Therefore, not only would we be reducing the funding for this year, but eliminating their ability to compete for block-grant funding in future years. Projects in approximately 40 States would be affected. I believe we have a commitment to our grantees to maintain these efforts to their completion.

Furthermore, if we terminate these programs at this time, we will lose the investment made in prior years. Both the adolescent health and the smoking and health programs have been operational only 1 or 2 years, and most of them are school-based and funded to coincide with the school year. HMO grantees would be entering their development phase after having completed their planning process, and no funds would be available for them.

Finally, smoking and health and adolescent health would be phased out before alternative funding became available through the block-grant mechanism in fiscal year 1982. This would result in a change in the distribution of block-grant funds awarded to the States.

We would be pleased to answer any questions which you and the committee would have. I hope that I have been able to convey to you the urgency of this request.

Senator SCHMITT. We will have some questions. It might be advisable at this point, if it would be a convenient time, to go vote and come back, and the other Senators will be able to join us. So we will recess for about 10 minutes.

[A brief recess was taken.]

BREAKDOWN OF THE SUPPLEMENTAL REQUEST

Senator SCHMITT. Back on the record.

Mr. Secretary, could you supply for the record, if you don't have it handy, a breakdown of how much each hospital would require within the $16.8 million request?

Dr. BRANDT. Yes, I can supply it, or I can respond right now.

Senator SCHMITT. Why don't we go ahead and respond right now.

Dr. BRANDT. Baltimore hospital will require $1.785 million of the $16.8 million; the Boston hospital, $1.245 million; the Nassau Bay hospital, $1.78 million; New Orleans, $3.59 million; Norfolk, $1.17 million; San Francisco, $1.345 million; Seattle, $1.996 million; and Staten Island, $3.88 million.

NEW ORLEANS AND STATEN ISLAND PUBLIC HEALTH SERVICE HOSPITALS

Senator SCHMITT. Why the significantly higher amounts for New Orleans and Staten Island?

Dr. BRANDT. It is principally because their revenues have fallen lower than at other hospitals. The overall issue is one of the census being down in all of our hospitals. For example, last year, in July of 1980, our average daily census throughout the system was 1,161. As of July 7—and admittedly, this is a 1-day sample, but it indicates the general trend—our census was 812. So we're down 30 percent.

Now, unfortunately, that's not such a great loss until one begins to look at the analysis of this by primary and secondary beneficiaries. Only secondary beneficiaries pay for their service, and the loss is almost entirely among the secondary, not in the primary beneficiaries such as merchant seamen who do not pay. So we have suffered a significant loss in income. And it has been heavier at those two hospitals than at the others. Indeed, at the Seattle hospital, the census is up at the present time, but the paying patients are down.

1981 RESCISSION AND OASH SUPPLEMENTAL

Senator SCHMITT. Did we not have any means of estimating that this would happen when you were before us for the $40 million supplemental?

Dr. BRANDT. Well, if you recall, Senator, not only was there a request for the supplemental, there was also a request for the rescission for about the same amount of money. The rescission was in the Health Services Administration supplemental in my office. In fact, the rescission was greater than we had requested, thereby resulting in less funds, not more funds, than we had initially proposed.

Senator SCHMITT. But the $40 million supplemental plus the $2 million less rescission provided by the Congress was specifically for the transition in the shutdown of the eight Public Health Service hospitals.

Dr. BRANDT. That's correct. That's correct. But two things happened.

Senator SCHMITT. In calculating those requests, did you include the problem of secondary beneficiaries?

Dr. BRANDT. No, sir; because at that time, the problem wasn't with us.

Senator SCHMITT. Couldn't it have been anticipated?

Dr. BRANDT. No indeed; if you had tried to project it, I think, if anything, you would have projected that revenues would have increased. Knowing that the hospitals were going to close, I would have thought that patients would want to come in and have their problems treated, particularly chronic problems. In fact, exactly the reverse has happened, patients have begun to find other sources of care much earlier than we had anticipated they would do it.

Senator SCHMITT. Mr. Secretary, I think our record ought to be clarified. You indicate that Congress did not follow the administration's request. On this issue, we did. The request for operations was $34 million in rescissions, and we rescinded $34 million.

Dr. BRANDT. Rescinded $36 million, I believe, sir.

Senator SCHMITT. The conference report indicates $34 million.

Mr. MAHONEY. The rescission for the PHS hospitals was exactly equal to the amount of the administration's request. The amount provided for the supplemental, however, was short by approximately $1.1 million, because you instructed that we absorb an additional rescission of $2.1 million for Bureau of Medical Services program support out of the $40 million that you appropriated for the supplemental. That additional rescission was not requested by the administration.

Asking us to absorb within the $40 million the amounts necessary for the payment of the salaries for the Bureau of Medical Services in effect left us $1.1 million short in the supplemental appropriation for the hospitals.

Senator SCHMITT. I don't know that we directed you to take that out of the supplemental, but we certainly gave you the authority to do that.

Mr. MAHONEY. Yes, sir.

Senator SCHMITT. And you chose to exercise that authority; right?

Mr. MAHONEY. This is how we are proceeding, but I would have to check the record to verify that you didn't direct us to use the supplemental to fund these program support costs.

THIRD-PARTY REIMBURSEMENTS

Senator SCHMITT. Was there any indication in May or June that these third-party reimbursements would be insufficient?

Dr. BRANDT. In our original projections, we projected through May that we would receive or collect $44.3 million. The amount that we are projecting through May is still $44.3 million.

In June we projected $5.8 million. And although we don't have the books closed on June at the moment our projections are now $4.6 million.

Several months ago, we projected $5.7 million income for July. On the basis of our current operations, we are projecting $3.5 million. Assuming that this trend continues, we are projecting $2.1 million for August and less than $1 million for September.

So that through May, our projections remain the same. It is only in June that our projections begin to change.

Senator SCHMITT. What level of third-party reimbursements would have been sufficient to cover your needs for the rest of the year?

Dr. BRANDT. We would have needed additional—we would have needed a total of $67.2 million for the year. We are now projecting $54.7, and that's the major problem.

Senator SCHMITT. Now, for the same period of time in 1980, what was your level of third-party payments? Or let me rephrase the question.

What was the 1980 number that corresponds to the $64 million, I think $64 or $67 million, that you just mentioned?

Dr. BRANDT. $56.8 million was the 1980 income. So we are projecting to be down $2.1 million in fiscal 1981 as compared to fiscal 1980.

Senator SCHMITT. You mentioned generally, the sources of your third-party funds. Could you be specific in how much money is involved from each source?

Dr. BRANDT. Seventy-one percent of the reimbursement income comes from the Department of Defense; 6 percent from State programs of one kind or another; 3 percent from community programs; 3 percent from the renal dialysis program; and 17 percent from everything else: medicare, private insurance, et cetera.

Senator SCHMITT. And the principal dropoff has been in DOD reimbursements?

Dr. BRANDT. Yes.

Senator SCHMITT. Is the DOD recipient a voluntary participant in the Public Health system?

Dr. BRANDT. Yes; they are a secondary beneficiary.

Senator SCHMITT. Were they encouraged to go elsewhere by the Department of Defense?

Dr. BRANDT. No, not to our knowledge. We have no indication of that, and in our discussions with them, there has been no indication at all of that.

Senator SCHMITT. You have discussed this with DOD?

Dr. BRANDT. Yes; we have discussed the whole transfer program, the whole problem with the hospitals. This is in large part, I think, something that is beyond their control. My guess is that since they know the hospitals are going to close anyway, they are starting to make arrangements for alternative sources of care.

PHS HOSPITAL AND CLINIC SYSTEM'S SHORTFALL

Senator SCHMITT. I will have some more questions.

Senator Rudman, do you have questions?

Senator RUDMAN. Thank you, Mr. Chairman. I would like to direct several questions, probably to Mr. Itteilag and anyone else on your panel who might like to respond.

When did you first become aware of the shortfall?

Dr. BRANDT. I first became aware of it on July 1.

Senator RUDMAN. Is there anyone in your organization who was aware of it prior to July 1?

Mr. KELSO. Yes; we knew that we were going to have a possible deficit, the extent of which we didn't know back, I would say, somewhere around May 1. For that reason we terminated contract patient care except for life-threatening emergencies. We thought that that would help our situation. Subsequently, however, the reimbursement levels fell off so dramatically.

Senator RUDMAN. At what point did someone within Mr. Itteilag's office, or possibly Mr. Kelso's or Mr. Marshall's office, not looking at your present budget, determine what was available within that budget for reprograming?

Dr. BRANDT. Let me correct an answer I gave you a moment ago. I was aware we were going to have a shortfall back in May. However, I thought we could accommodate that through several management actions indicating reductions in contract care. I was not aware of the severe magnitude until July.

Senator RUDMAN. We were working on a supplemental at that time?

Dr. BRANDT. That's correct.

We began to look at other possibilities, actually, in May, to cover the shortfall. But we thought we could handle that by reducing the contract care.

And also at that same time, we reduced a number of other things. For example, we decreased the use of outside consultants. We eliminated most maintenance and repairs on the buildings, at a saving of about $2½ million. We reduced our consumption of supplies. We stopped equipment purchases, et cetera. But we thought that we would be able to get by with those kinds of changes.

In fact, two things happened. One was the courts ordered us to resume contract care. Therefore, we went back to business as usual. And then, the second thing is that revenues dropped at a much faster rate than we anticipated.

REPROGRAMING FUNDS FROM OASH ACCOUNT

Senator RUDMAN. Well, looking at your obligations-by-activity chart furnished the committee, with a July 16, 1981 date, second column, fiscal year 1981 obligations through June 30, 1981, 86.448, how accurate is that figure?

Mr. MAHONEY. That's an accurate figure, sir.

Senator RUDMAN. That is an accurate figure?

Mr. MAHONEY. As of June 30.

Senator RUDMAN. So your accounting and management controls are good enough so that roughly 20 days following that date, you can sit here and tell us that that money has in fact been obligated or spent?

Mr. MAHONEY. Yes, sir.

Dr. BRANDT. It's been obligated, not necessarily spent.

Senator RUDMAN. I said "or spent."

And you are confident of that figure?

Dr. BRANDT. That's correct.

Senator RUDMAN. And thus the third, fourth, and fifth columns represent some sort of summary of internal planning of your own that leads you to tell us that, essentially, the two figures together, basically the third, fourth, and fifth columns when added together and added to the second column, will, of course, come out to the first column, which essentially tells the committee that you have no money to reprogram?

Mr. MAHONEY. That's correct.

Senator RUDMAN. Let me ask you a question, because I don't understand something here at all. I want to look at something that is just unrelated in terms of what we're talking about, but very related in terms of what we're trying to do.

I would like to look at the sixth or seventh item down, entitled "Smoking and health." It shows 12.062 available for fiscal year 1981. It shows a little over $1 million spent in the entire 6 months. And then, all of a sudden, we look over here to the continuation requirements, and you've managed in the last 6 months to essentially use 90 percent of what you originally had budgeted. Can you explain that to me?

Dr. BRANDT. Yes, sir; the funding of those programs coincide with the school year. These are programs that are principally aimed at providing educational programs to discourage smoking and alcohol consumption, as directed by the Congress, to school-age kids. Therefore, most of these grants are awarded in July and August, and some in early September. So we award the money just before the school year begins, generally for the entire year.

The $1.8 million that have already been funded are an anomaly. We have funded some school systems at other times during the year, other than the beginning of the school year. But the bulk of them are at the beginning.

CONTINUATION GRANTS

Senator RUDMAN. So what you are telling us here today is that you are fully confident that without a supplemental bill to meet a requirement that we all tend to agree with, without a supplemental, we are going to have no money to reprogram whatsoever. If we refuse the supplemental, it just will be impossible.

Dr. BRANDT. No, sir; it wouldn't be absolutely impossible. The $35 million which is in continuation grants, commitments that the Government has made, could be reprogramed and need to keep the hospitals open. That could be done.

However, in my judgment, we would basically be crippling those programs. If you subtracted the amount available for new awards, $3.3 million, from $16.8 million, you would need to reprogram about $13½ million per continuation awards, which is nearly 40 percent of the continuation awards requirement.

So we would have a choice either of reducing everybody across the board by 40 percent, which in most cases would effectively terminate the program, or we could selectively eliminate funding for specific renewals.

Senator RUDMAN. There are no entitlements here that I know of.

Dr. BRANDT. No entitlements.

Senator RUDMAN. I just want to point out to you—Mr. Chairman, I'll wind up here—you are asking us, with roughly 79 days, 80 days—less than that, really—70 days between now and the end of the fiscal year—you are asking this subcommittee to go to full appropriations. You're asking us to get a supplemental with 71 days left. You're asking us and our chairman to take it on the floor of the Senate and hope, in this rather difficult time, that we won't have it looking like a Christmas tree by the time that we get to the end of it. And we may fail; we may not get it through.

And I don't think that anyone on this committee that I've talked to disagrees with the need for these funds. And I hope you all understand the risk you are taking in not coming to us with the stroke of a pen, essentially, getting agreement to reprogram these funds and get these hospitals on an even keel until October 1. Because this supplemental at this time, in my opinion—I'm relatively inexperienced, but from what I can see, it poses great problems to get this supplemental through at this time.

And I certainly think if you had gone for reprograming and had worked and put some real effort into these last three columns to see if there's any way to do it, that we might have been better off.

That's just one Senator's opinion, and I'm going to do whatever the chairman wants to do on this, because he's got to carry the load. But I'll tell you that it seems like a strange time. We're considering the tax bill; we've got a reconciliation conference going. And you're now coming in with a supplemental with 71 days left, when you've got roughly $86 million in a budget you might move around.

So I'm just going to tell you, sir, I admire your courage.

Dr. BRANDT. Let me assure you——

Senator RUDMAN. Maybe not your judgment, but your courage. [Laughter.]

1981 OASH SUPPLEMENTAL

Dr. BRANDT. By the way, Senator, of that $56 million in the category, $40 million of it is the hospitals budget.

Senator RUDMAN. I did notice it.

Dr. BRANDT. I do wish it wasn't necessary for us to be here, quite frankly, because I would rather not be coming in for reprograming. And we wouldn't be here if it wasn't, in our judgment, essential.

Senator RUDMAN. Thank you, Mr. Chairman.

Senator SCHMITT. Thank you, Senator.

Is there no maneuvering room at all in the administrative mandatories column, Mr. Secretary?

Dr. BRANDT. Of the $56.4 million in that column, $40 million is for the hospitals themselves. The bulk of the remaining $16.4 million is in salaries of personnel currently on board. Because of these requirements, there is little available for reprograming.

Senator SCHMITT. Would you agree that there's about $1 million of travel, supplies, equipment, and consulting in that total?

Dr. BRANDT. Sure, yes; I said the bulk of it is personnel. I think there is slightly over $1 million in for that purpose. And there's $3.3 million there for new awards that have not yet been made, although the decisions on them have already been made.

NEED FOR SUPPLEMENTAL REQUEST

Senator SCHMITT. Mr. Secretary, in the fiscal year 1981 rescission bill, Congress, responding to the administration's request, cut more than $2 billion out of the Labor-HHS appropriations. Just recently, the administration requested fiscal year 1981 rescissions of another $100 million in HHS programs in an effort to reduce spending and curb inflation, as part of their economic program. Those requests are antithetical to this $16.8 million supplemental.

The inconsistency in the approach, I guess, you have explained—that there was no way you could have anticipated the news that you received July 1.

Dr. BRANDT. At least, we certainly didn't. And as far as I know, I don't see how we could have anticipated it.

Senator SCHMITT. Are there any more of these glitches lurking out there that we should know about?

Dr. BRANDT. I hope not, sir.

Senator SCHMITT. We might as well do them all now if we're going to have a supplemental.

Dr. BRANDT. There are no more in the Public Health Service that I'm aware of. I hope there aren't any at all, sir.

Senator SCHMITT. Is there any fat in this $16.8 million?

Mr. Kelso. Mr. Chairman, we believe, given the data that we have—and considering the lag in the data that comes in on reimbursements—that the $16.8 million is adequate to get us through the rest of this fiscal year.

Dr. BRANDT. We will only spend what we absolutely need.

Senator SCHMITT. What if 2 weeks before the end of the fiscal year you're out of money again? What are you going to do?

Dr. BRANDT. I don't think I will be coming back. [Laughter.]

Senator SCHMITT. Would you ask for a reprograming at that point?

Dr. BRANDT. I would not. I honestly believe that the programs that are in here for fourth-quarter obligations are sufficiently important—as does the Secretary, and Mr. Stockman—that reprograming is just not indicated.

HEALTH SERVICES RESEARCH

Senator SCHMITT. The 10-program continuation requirements problem, back to your chart, you have $10,967,000 in health services research?

Dr. BRANDT. Yes, sir.

Senator SCHMITT. Could you explain that?

Dr. BRANDT. Health services research is a program which is oriented to the development of improved methods of delivering care. I have here a breakout, by the type of project, which may be helpful.

Senator SCHMITT. Do we have that in front of us?

Dr. BRANDT. No, sir, you do not have it, but we will make a copy of it available to you.

[The information follows:]

NCHSR fiscal year 1981 research budget by research category

	Estimated expenditures
Health care costs and expenditures	$1,800,000
EMS/ambulatory care	3,400,000
Health insurance/finance	2,600,000
Health manpower	1,200,000
Promotion/prevention	700,000
Long-term care	1,400,000
Planning and regulation	900,000
Quality of care	2,900,000
Disadvantaged	700,000
Special studies	1,472,000
Technology and computer science applications	3,400,000
Subtotal	20,472,000
Health Services Research centers	1,005,000
Dissemination	972,000
Total	22,449,000

[1] Intramural research is included in the research category distribution under Health Services Research.

RESEARCH PROGRAMS

Dr. BRANDT. For example, it includes projects to study health care costs and methods for approaching their control and/or reduction. It includes programs in emergency medical services and its organization. It includes health insurance and health manpower studies, studies in prevention of disease and promotion of health, studies of long-term care, quality of care, computer applications to health care, et cetera. So it's a series of programs that are oriented to improve the delivery system.

Senator SCHMITT. If that money were not there for the remainder of this fiscal year, it would not have as significant an impact as, say, the money for adolescent health or smoking and health, and so forth, would it?

Dr. BRANDT. These are noncompeting continuations, Senator. So it would mean cutting all of those investigators off in the middle of their project, or at some place in the project before its end.

Senator SCHMITT. Is there money for those programs to come up to speed again? At what level do you anticipate requesting funds for 1982? What is the administration request?

Dr. BRANDT. The administration request in 1982 is a reduction of about $10 million below 1981. We would be able to phase those out that are ending, to develop a few new ones. But our fiscal year 1982 budget would fund all continuations.

Senator SCHMITT. You don't think those researchers could find something else to do for the next few months, while we salvage the Public Health hospitals?

Dr. BRANDT. You mean delay the payment of their grant until then?

Senator SCHMITT. Until the 1982 money was available.

Dr. BRANDT. Having just come from a university——

Senator SCHMITT. It would probably be on a continuing resolution, unfortunately, so the money will be there.

Dr. BRANDT. Having just come from a university, I would say, having been a dean, the first order I would have given them was to fire their employees, effective immediately, if the grant money was not at hand.

Senator SCHMITT. Let us have that list for our records, please.

Dr. BRANDT. We will.

I think the other significant program is the health maintenance organization program, because these are organizations that have completed their planning and feasibility studies and now are in the development stage. I don't know what the total impact would be of reducing that money, but I think it would probably stop some of those health maintenance organizations' efforts toward development.

These are the last ones that will be federally funded, you know.

Senator SCHMITT. Well, in 1982, according to the administration's request, you're cutting $10 million out of that program.

Dr. BRANDT. That's correct, because we will no longer be giving grant funds to support operational programs. There will be loans, but no more grants, as these are.

UNCERTAINTY OF THE PASSAGE OF THE SUPPLEMENTAL REQUEST

Senator SCHMITT. I hope you understand my problem. My problem is, I'm not sure I can get your bill through the Senate.

Dr. BRANDT. Yes, sir; I understand the problem.

Senator SCHMITT. You know, if it were at all possible for me to take that 10.9 and add it to the 3.3 and, say, 1.1 that might be called lower priority aspects of administrative mandatories—and let me assume that you've got a little bit of fat in the 16.8—I can make it with the reprograming.

Dr. BRANDT. I understand the dilemma of trying to get one through. I can only say that I think the continuity of that research effort is sufficiently important that we would prefer not to pull that money out for the Public Health Service.

Senator SCHMITT. Let me put it this way: If that were what you needed money for, would you be up here asking for a supplemental?

Dr. BRANDT. I probably wouldn't be able to, that's correct. If you ask me, the answer is, "Yes," I would be.

FURLOUGHS

Senator SCHMITT. What is your schedule for furloughing Public Health Service hospital staff?

Dr. BRANDT. We have advised the temporary staff that they will be separated on August 1. Assuming that there are no additional funds, our plan is to cease all inpatient admissions on August 1 and furlough all of the part-time, permanent staff on August 15. With the exception of 250 maintenance and security people, the permanent staff would be furloughed between August 22 and September 9, 1981.

Now, that excludes the Commission Corps, who, under their rules, cannot be furloughed. They would be transferred to other activities, probably primarily the Indian Health Service.

We would close the clinics on September 1. Hospitals would be closed some time in August or September, as the patients who were in the hospital recover and/or arrangements can be made to put them in other institutions.

Senator SCHMITT. Have you itemized the procedures that you're required to follow under law?

Dr. BRANDT. Yes, sir.

Senator SCHMITT. Could we have an outline of those for our record?

Dr. BRANDT. Yes, sir.

[The information follows:]

PART 351—REDUCTION IN FORCE

Nomenclature Change: A document published at 44 FR 47523, Aug. 14, 1979, made general nomenclature changes to the Office of Personnel Management regulations in this chapter.

Subpart A—[Reserved]

Subpart B—General Provisions

Sec.
351.201 Use of regulations.
351.202 Coverage.
351.203 Definitions.
351.204 Responsibility of agency.
351.205 Authority of OPM.

Subpart C—Transfer of Function

351.301 Transfer of employees.

Subpart D—Scope of Competition

351.401 Determining retention standing.
351.402 Competitive area.
351.403 Competitive level.
351.404 Retention register.

Subpart E—Retention Standing

351.501 Tenure groups and subgroups—competitive service.
351.502 Tenure groups and subgroups—excepted service.
351.503 Length of service.
351.504 Performance rating.
351.505 Records.
351.506 Effective date of retention standing.

Subpart F—Release From Competitive Level

351.601 General.

Sec.
351.602 Order of release from competitive level.
351.603 Actions.
351.604 Use of furlough.
351.605 Liquidation provisions.
351.606 Mandatory exceptions.
351.607 Permissive continuing exceptions.
351.608 Permissive temporary exceptions.

Subpart G—Assignment Rights

351.701 Qualifications for assignment.
351.702 Exception to qualifications.
351.703 Assignment involving displacement.
351.704 Rights and prohibitions.
351.705 Administrative assignment.

Subpart H—Notice to Employee

351.801 Notice period.
351.802 Content of notice.
351.803 General and specific notices.
351.804 Content of general notice.
351.805 Expiration of notice.
351.806 New notice required.
351.807 Status during notice period.

Subpart I—Appeals and Corrective Action

351.901 Appeal.
351.902 Correction by agency.

Subpart J—Establishment and Maintenance of Reemployment Priority List

351.1001 Establishment of list.

Authority: 5 U.S.C. 1302, 3502, unless otherwise noted.

Source: 33 FR 12429, Sept. 4, 1968, unless otherwise noted.

Subpart A—[Reserved]

Subpart B—General Provisions

§ 351.201 Use of regulations.

(a) Each agency shall follow this part when it releases a competing employee from his/her competitive level by separation, demotion, furlough for more than 30 days, or reassignment requiring displacement, when the release is required because of lack of work, shortage of funds, reorganization, reclassification due to change in duties, or the exercise of reemployment rights or restoration rights.

Subpart H—Notice to Employee

§ 351.801 Notice period.

(a) Each competing employee selected for release from his or her competitive level under this part is entitled to a written notice at least 30 full days before the effective date of his or her release.

(b) The notice shall not be issued more than 90 days before release except when the agency determines that additional time will protect employee rights or avoid administrative hardship.

(c) When an agency retains an employee under § 351.606 or § 351.608 the agency may not continue the notice period beyond the employee's retention period. The notice to the employee shall cite the date on which the retention period ends as the effective date of the employee's release from his or her competitive level.

(5 U.S.C. 1104; Pub. L. 95-454, sec. 3(5))

[44 FR 54693, Sept. 21, 1979]

NOTIFICATION OF FURLOUGH

Senator SCHMITT. The staff members in the various hospitals are aware of the current situation and what is required of them?

Dr. BRANDT. Under the rules, we had to notify our employees at least 30 days ahead of time. So on July 15 every employee except the members of the Commission Corps received a letter informing them of the possibility that their employment might be terminated August 1, if they are temporary employees, or furloughed as of August 15 or 22 if they are full-time permanent employees. So those letters have been delivered.

It's only informing them of the possibility, by the way. It does not implement the furlough.

Senator SCHMITT. Do some of those policies you must follow include steps outlined under the Administrative Procedures Act?

Mr. KELSO. We followed civil service employment regulations, which require, as Dr. Brandt said, that we give employees 30-day notices before they are actually furloughed.

Dr. BRANDT. I really don't know the answer to the question, Senator.

Mr. KELSO. We followed the regulations of personnel management within the civil service system.

PHS BILL LANGUAGE

Senator SCHMITT. The bill language that you have proposed to us appears to be in error in that it increases the current operating ceiling from $16.8 million but would seem to exclude your using the $40 million termination supplemental and third-party reimbursements.

Do you agree with that interpretation of the language?

Mr. MAHONEY. Yes; that is an error. We agree with your interpretation, sir. That was an oversight on our part.

We would recommend the same language that's currently in the Rescission Supplemental Appropriations Act.

Senator SCHMITT. You mean currently in the House?

Mr. MAHONEY. The House and the Senate.

Senator SCHMITT. The subcommittee bill? Are you referring to the bill that's been passed, the rescission supplemental bill?

Mr. MAHONEY. Yes.

Senator SCHMITT. OK.

It has been suggested by the staff that we might make a proviso as follows: "Provided that not more than $145,199,000 shall be available under this head for operations of the Public Health Service hospitals and clinics."

Mr. MAHONEY. I agree.

GAO REPORT ON PHS HOSPITALS

Senator SCHMITT. You're familiar with the June 10 report on Public Health hospitals the General Accounting Office published, in which it noted that the hospitals and clinic staff do not require all persons to furnish documented evidence of eligibility, were lenient in reviewing that evidence, and rarely verified the accuracy of the evidence given?

Dr. Brandt. I am familiar with that. The report has been released. Of course, it deals principally with contract care, which we are in the process of tightening up anyway.

Mr. Kelso. Mr. Chairman, we concur with six of the eight recommendations in the report. As a result we are attempting to install improvements in the system. As the report indicates, the recommendations are contingent on whether the hospital system continues. We did, however, agree with six of the eight recommendations.

Senator Schmitt. Do you think presently there is a significant loss of resources as a result of the problems outlined by the GAO?

Mr. Kelso. That's very hard to tell, Mr. Chairman. I'm sure that if we tighten up the procedures, we would possibly show some savings. But I wouldn't want to relate the problems in the GAO report to the problems we have with the deficit at the present time. Our current problem really relates to reimbursements.

Senator Schmitt. Is there some tendency to relax on the eligibility issues since you are phasing out your responsibility for these hospitals?

Mr. Kelso. I don't think so. I believe that if GAO were to have conducted a study a year or so ago, they would have come up with the same findings. I don't think there's any relationship.

As Dr. Brandt said, we have not been in the contract-care business since May 8, with the exception of the time in the court, which put us back into business under the restraining order.

Senator Schmitt. While you're under a court order, are you continuing to try to minimize the number of ineligible persons treated?

Mr. Kelso. Yes, sir.

Dr. Brandt. We're out from under that court order now, by the way. We appealed the order and were upheld by the court, so that we could, in fact, implement all of the measures such as stopping contract care and reducing the other expenditures that I have outlined.

HSA APPROVALS

Senator Schmitt. Do your closure plans require approval of local health systems agencies before you proceed?

Dr. Brandt. No, sir.

Senator Schmitt. But the communities who wish to take over operation must get HSA approval before they can do that?

Dr. Brandt. I am not sure of that point.

Mr. Itteilag. Senator, if I could comment on that. If the reconciliation act is finalized in much the way it's now drafted by the House and the Senate, that approval will no longer be required, because that section of the law would be repealed by the reconciliation act.

Senator Schmitt. Is it now required?

Mr. Itteilag. I would say there's a question of that. I think that the court case which Dr. Brandt recently referred to, that we ultimately won, suggested that the dollar-limitation language in the Supplemental and Rescission Act, Public Law 97–12, substantially had the effect of repealing those provisions of Public Law 93–155 that referred to Public Health Service hospitals. And it was in Public Law 93–155 that we were prohibited from reducing the level or range of services. And in that same law, we were also required to get the approval of these health planning agencies.

EFFECT OF 1973 LAW

Senator SCHMITT. And the court's interpretation was that the dollar-limitation language effectively repealed an act of Congress?

Mr. ITTEILAG. Senator, the Congress, in acting through the appropriations process in limiting the amount of money we could spend, in effect, said, "You have to cut back the level of services." And therefore, to that extent, the old law was no longer deemed to be the applicable law.

Now, I cannot speak as an attorney on the matter. But that is my understanding. And in fact, Senator, it was one of the reasons why we placed—the Department requested that the dollar-limitation language be in the Supplemental and Rescission Act in the first place.

I would say this, Senator. If the dollar-limitation language had not been in the Supplemental and Rescission Act, we would not have won that court case, because the provisions of Public Law 93-155 with respect to the level and range of services and the approval of the health planning agencies would have still been applicable. That would be so at least until the reconciliation act passes, if the reconciliation act includes the repeal.

COMMUNITY TAKEOVER OF PHS HOSPITALS

Senator SCHMITT. Yes; but how does the current situation affect local takeover of these hospitals? We did nothing to change that.

Dr. BRANDT. Senator, there's a fair amount of disagreement among all of us—I was under the impression that it's true in all cases. There is some variability, as you go from State to State, of the certificate-of-need programs. So if it's all right with you, let us get that information and get it to you very quickly.

Senator SCHMITT. I hope you will, on each of the hospitals.

[The information follows:]

PHS facility	Certificate-of-need—CON—requirements
Baltimore, Md	State CON requirement includes transfer of facilities. Bed needs licensed and CON issued. Issued by Maryland Comprehensive Health Care Agency, State Health Planning and Development Agency (SHPDA), Department of Health and Mental Hygiene.
Boston, Mass	State requirement is called Determination of Need (DON). Issued by Office of State Health Planning.
Nassau Bay, Tex	State CON requirement. Beds will need licensing and CON. Issued by Texas Health Facilities Commission.
New Orleans, La	No CON legislation in Louisiana.
Norfolk, Va	State CON requirements will be required. Issued by State Health Commission.
San Francisco, Calif	State CON requirement. Reversion to Department of Defense does not require review.
Seattle, Wash	Acquisition with notification to State; will not be required to go through CON process. Issued by Department of Social and Health Services, CON supervision.
Staten Island, N.Y	State CON requirements will be required. Facility will be treated as new facility for code requirement. Issued by State Health Department.

IMPOUNDMENT OF FUNDS FOR PHS HOSPITALS

Senator SCHMITT. Is there any money, Mr. Secretary, that has been provided overall for Public Health Service hospitals and clinics that would be subject to rescission or deferral in the future?

Mr. MAHONEY. No.

Senator SCHMITT. You expect to fully deplete the available resources?

Mr. MAHONEY. Yes, sir.

1982 RECONCILIATION BILL

Senator SCHMITT. Does the reconciliation bill contain language that will give us authority to appropriate funds for next year's expenditures in Public Health Service hospitals?

Dr. BRANDT. Yes, sir; it does. In both the House and the Senate versions, it directs the Secretary to evaluate community proposals and, on the basis of that evaluation, to determine which hospitals are likely to continue to operate under community sponsorship. Those hospitals would continue to operate, through March of 1982, in the Senate version, and through September of 1982, in the House version, before they are taken over by the community. So that does permit the Congress to appropriate funds for the continued operation of those hospitals, either way.

Mr. ITTEILAG. Senator, if I could comment on that as well, there are two other points I would make.

One is that the Senate version of the bill does make any provisions of what will be a new authorization subject to the amount of money available. So that for us to carry out the policy, this body and the House would have to, in fact, appropriate the money.

And second, the Senate version of the reconciliation bill, in addition to certain specific authorizations, contains authorizations which limit the appropriations to several of the Public Health Service agencies, one of which is the Health Services Administration. If that overall limitation on the Health Services Administration should prevail in conference, it is my feeling that you will not have the flexibility to appropriate amounts in excess of that amount which is now pending in the fiscal year 1982 budget for the Public Health Service hospitals. If you were to do that, it would be at the expense of other funds—at the expense of other activities within the Health Services Administration.

So the situation is, I would say, fraught with some danger as to where we will ultimately come out on this matter.

Dr. BRANDT. That would also, of course, Mr. Chairman, put a limit on the amount of money that could be used. For example, Seattle's plan has requested a total of $56½ million for fiscal 1982. That includes capital improvements as well as operating moneys. Clearly, the limitation that was just referred to would also put a cap on the possibility of Congress doing anything to assist in that kind of transition expenditure.

CLOSURE OF THE PHS HOSPITAL AND CLINIC SYSTEM

Senator SCHMITT. Is there a 1973 law that prevents you from closing any of the Public Health Service hospitals until Congress expressly provides for such closing?

Dr. BRANDT. Public Law 93–155, which we were discussing awhile ago, goes even further in that it requires us to maintain the same level of service. It was ruled by the courts that Congress' action in decreasing the budget did in fact have the same effect of overriding these provisions. The Court, in effect, ruled that the Anti-Deficiency Act prevailed. The judge ruled that you can't operate them if the Congress does not give you adequate money.

So in fact, under the court ruling, we can close them because of budgetary limitations. That was the dilemma we were in when we pursued this.

Senator SCHMITT. Is that decision being appealed?

Dr. BRANDT. That decision? To my knowledge, it has not been appealed by the union. The union sued us and got a temporary restraining order. As a matter of fact, they got a permanent injunction. We appealed that, and the appellate court upheld us.

As far as I know, it has not been appealed further by the union.

Senator SCHMITT. Has this precedent ever been established before? Does the Anti-Deficiency Act take precedence over substantive law?

Dr. BRANDT. I don't know, sir, whether that's ever been used before or not.

Mr. ITTEILAG. But, Senator, there are many precedents for limitations in the appropriations acts superseding substantive law. In fact, the Court, the Supreme Court ultimately agreeing with congressionally imposed limitations on the use of this Department's funds for abortion is an example of that.

STATUS OF COMMUNITY TAKEOVER OF PHS HOSPITALS

Senator SCHMITT. I believe we've been provided material on the status of each community's plan for takeover of the PHS hospital in their area. We will include that in our record of this session.

[The information follows:]

COMMUNITY CONVERSION PROPOSAL STATUS

Boston.--The Allston Brighton Community Development Corp. (ABCDC) has submitted a letter of intent to acquire the Boston facility. The ABCDC's intent is not to operate a hospital but to act as a landlord for a number of tenant organizations, together with the establishment of a 75-unit housing complex. The health-social service components will include a senior citizens' multiservice center, an inpatient adolescent psychiatric unit, a community mental health center, an alcohol detoxification unit, and an alcoholic rehabilitation program. The letter of intent indicates that funds will be requested to subsidize the conversion for the health component of the program, but other funds will be sought for the social service and housing uses. No specific budget estimates have been given.

Baltimore.—The Wyman Park Health System will be established under initial auspices of the patient advisory group of the hospital with a medical group which is academically associated with institutions of the Johns Hopkins University, and with the North Central Baltimore Corp. of the city of Baltimore. It proposes to provide a comprehensive range of health services modeled on what is presently available. It will serve as a center for medical training and research through its affiliation with Johns

Hopkins University and in addition will have an active occupational health unit. The proposal anticipates conversion will take the better part of 12 months. The requested Federal subsidy for fiscal year 1982 contained in the initial proposal is $26.5 million. This includes $10 million operating capital, $1.5 million for training and research, and $15 million for capital improvement. The initial proposal also requests a working capital subsidy of $4.5 million in fiscal year 1983.

Nassau Bay.—Two requests have been received for the facility at Nassau Bay. The city of Nassau Bay has requested that the facility be conveyed to it. The city's intent is to lease the hospital to a proprietary hospital chain as a mechanism for generating income for the city. It requests a fiscal year 1982 Federal subsidy of $3,788,000.

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New Orleans.—No local community interest has been evidenced. However, during the last week of June, the Veterans Administration indicated interest in acquiring the hospital for conversion to a long-term care facility. The Veterans Administration is completing its feasibility survey and will decide by the end of July whether to proceed.

Norfolk.—A consortium including the city of Norfolk and the Eastern Virginia Medical Authority has submitted a proposal. Continued operation of this facility is essential to the teaching program of Eastern Virginia Medical Authority. The intent of the proposal is to operate as a general hospital for 1 year, during which decisions would be made with respect to the future uses. The fiscal year 1982 Federal subsidy request is $2,930,550. This includes $2 million to subsidize ambulatory care costs, $243,050 for other educational costs, and $687,500 for the alcohol detoxification unit.

Seattle.—A public authority will be established with support from the city and the State. The plan is to operate as a community hospital. Most of the current employees will be retained and there will be a contract with the medical group comprised of the current medical staff. The Federal costs would be $48.9 million, of which $39.7 million is for renovation.

San Francisco.—Under terms of the deed by which the Public Health Service initially acquired the facility, ownership reverts to the Army should PHS terminate operations. We have been informed by the Defense Department that the Army intends to exercise that option, but not to operate the facility as a general hospital. Rather, some services, largely administrative, but also including dental services, will be moved from the Letterman Army Hospital to the PHS facility. A request has also been received from the State of California, Office of the Governor, and the California Rural Indian Health Board for the Department to transfer ownership of the facility to the Indian Health Service. We have taken the position that Indians constitute a negligible portion of the patient workload, less than 5 percent, and that this does not justify operation of an Indian Health Service facility. However, we have indicated a willingness to consider a proposal from the State or the tribal organization for them to assume total operation of the facility using funds already available to them for other purposes from the Indian Health Service.

Staten Island.—In terms of the medical necessity to the community, this hospital is the one which is most essential for continued operation as a community facility. St. Vincent's Hospital, the closest neighboring hospital on Staten Island, has submitted a letter of intent for its willingness to operate the facility as a community hospital. St. Vincent's plans to establish a separate board with representation from the community as well as from the other two voluntary hospitals on the island. The Archdiocese and the Sisters of Charity have agreed to support this proposal. No formal budget proposal has been discussed but I anticipated a request for a operating Federal subsidy of about $2.6 million with some facility renovation also to be requested. That, however, is currently the subject of an ongoing architectural study and the number will not be available until close to August 15.

CONTINUATION PROJECTS

Dr. BRANDT. We will also provide to you, sir, a list of all of the Health Services Research continuation projects by institution, by amount of money, and by subject area.

[The information follows:]

Fiscal Year 1981
NCHSR Grant Continuations: OBLIGATED

Research Subject Area	Grant Title	Institution	Fiscal Year 1981 Total Grant Award
Health Care Costs & Expenditures	The Iowa Capitation Study	University of Iowa Iowa City, Iowa	$ 239,687
Health Care Costs & Expenditures	The Cost Dynamics of Critical Illness	Boston University Boston, Massachusetts	114,914
Health Care Costs & Expenditures	Improving the Quality of Drug Use in Nursing Homes	University of Maryland Baltimore, Maryland	247,927 *
Emergency Medical Services and Ambulatory Care	Assessing Emergency System Quality, Method Development	University of California Los Angeles, California	230,392
Emergency Medical Services and Ambulatory Care	Quality of Care in Acute Myocardial Infarction	McMaster University Medical Center, Hamilton, Ontario	48,886
Emergency Medical Services and Ambulatory Care	Regional Emergency Service for Low Weight Newborns	Health Policy Analysis and Acct. Network, Edgewood, N.M.	165,133
Emergency Medical Services and Ambulatory Care	Validation of Quality Assessment Measures in Emergency Medical Services	Yale University New Haven, Connecticut	191,716
Emergency Medical Services and Ambulatory Care	Severity Index Constructions: Methods, Emergency Medical Services Applications	University of Florida Gainsville, Florida	28,880 *
Health Manpower	Turnover and Absenteeism Among Hospital Employees	University of Iowa Iowa City, Iowa	90,394
Long Term Care	Drug Prescribing and Evaluations by Pharmacists in Skilled Nursing Facilities	University of So. California Los Angeles, California	103,350
Long Term Care	Panel Study of Massachusetts Elders	Harvard Medical School Boston, Massachusetts	182,366
Long Term Care	Cost and Efficacy of Home Care for Patients with Chronic Obstructive Pulmonary Disease	University of Washington Seattle, Washington	261,723 *
Long Term Care	Randomized Trial of a New Team Approach to Home Care	University of Rochester Rochester, New York	142,731 *

Research Subject Area	Grant Title	Institution	Fiscal Year 1981 Total Grant Award
Quality of Care	Support Systems, Stress and Primary Health Care	Harvard School of Public Health, Boston, Mass.	92,680
Health Care and the Disadvantaged	An Economic Analysis of Neighborhood Health Centers	National Bureau of Economic Research, Cambridge, Mass.	70,366
Health Care and the Disadvantaged	Access to Services by the Black Urban Elderly	Washington University St. Louis, Missouri	75,412 *
Technology and Computer Science Applications	Analysis of Clinical and Managerial Data	Beth Israel Hospital Boston, Massachusetts	77,960
Technology and Computer Science Applications	Telehealth in Anesthesia: Model for a Network	University of Pittsburgh Pittsburgh, Pennsylvania	348,449
Technology and Computer Science Applications	Evaluation of a Summary Medical Record System	University of California San Francisco, California	110,283
Technology and Computer Science Applications	Evaluation of Medical Diagnostic Technology	Harvard College Cambridge, Massachusetts	376,337 *
Special Studies	Cost Effective Methods for Collecting Health Data	University of Illinois Urbana, Illinois	117,812
Special Studies	Health Services Developmental Grants	McGill University Montreal, Quebec	110,000
Special Studies	Health Services Research Grants	Stanford University Medical Sch. Stanford, California	100,000
Special Studies	Health Care Technology Grants	Georgetown University Washington, D.C.	90,000
Health Services Research Centers	Health Care Management Center	University of Pennsylvania Philadelphia, Pennsylvania	495,000
Health Services Research Centers	Health Services Policy Analysis Center	Univ. of California Medical Sch San Francisco, California	509,999
			$4,622,397

Fiscal Year 1981
NCHSR Grant Continuations: UNOBLIGATED Awards Pending

Research Subject Area	Grant Title	Institution	Pending Fiscal Year 1981 Total Grant Award	Anniversary Date
Health Care Costs & Expenditures	Reducing Clinical Laboratory Costs	University of California San Francisco, California	$ 132,251	Sept. 1
Health Care Costs & Expenditures	"Per Case" versus "Per Service" Reimbursement	Johns Hopkins University Baltimore, Maryland	117,317	Sept. 30
Emergency Medical Services and Ambulatory Care	Behavioral Outcome in Head Injury	University of Washington Seattle, Washington	145,880	Sept. 1
Emergency Medical Services and Ambulatory Care	Emergency Medical Service Effectiveness Research	University of Wisconsin Madison, Wisconsin	592,748	Sept. 15
Emergency Medical Services and Ambulatory Care	The Effect of Telemetry on Advanced Life Support Care	University of Pennsylvania Philadelphia, Pennsylvania	163,234	Sept. 30
Emergency Medical Services and Ambulatory Care	Impact of Emergency Medical Services System Development in Rural Areas	Health and Hospitals of Boston, Inc. Boston, Massachusetts	498,996	Sept. 30
Emergency Medical Services and Ambulatory Care	Improving Drug Prescribing in Family Practice	Duke University Durham, North Carolina	76,401	Sept. 30
Emergency Medical Services and Ambulatory Care	The Effectiveness of Mobile Intensive Care	Duke University Medical Center Durham, North Carolina	27,116	Sept. 30
Health Insurance	Dental Care Demand: Insurance Effects and Plan Design	University of Washington Seattle, Washington	162,048	Sept. 1
Health Manpower	Effectiveness in Physician-Nurse Practitioner Teams	Harvard Community Health Plan Boston, Massachusetts	36,272	Sept. 1
Health Manpower	Predictive Validity of Medical Specialty Examinations	Michigan State University East Lansing, Michigan	211,828	Sept. 1
Health Manpower	Methods to Improve Quality of Physician Prescribing	Vanderbilt University Nashville, Tennessee	236,630	Sept. 30

Fiscal Year 1981
NCHSR Grant Continuations: UNOBLIGATED Awards Pending

Research Subject Area	Grant Title	Institution	Pending Fiscal Year 1981 Total Grant Award	Anniversary Date
Long Term Care	Correlates of Long Term Care Expenditures and Service Utilization	University of California San Francisco, California	$ 149,984	Sept. 30
Competition and Regulation	Competition Studies in Health Services	Duke University Durham, North Carolina	99,903	Sept. 30
Quality of Care	Choice and Predictability in Health Care Settings	Vanderbilt University Nashville, Tennessee	132,295	Sept. 15
Quality of Care	Ambulatory Care Medical Audit Demonstration Project	Harvard School of Public Health, Boston, Mass.	568,747	Sept. 30
Quality of Care	Profile-Based Dental Utilization Review System	University of Connecticut Farmington, Connecticut	258,348	Sept. 30
Quality of Care	Self-Care: Practices and Attitudes in the United States	University of Chicago Chicago, Illinois	82,960	Sept. 30
Technology and Computer Science Applications	Computer-Stored Ambulatory Record (COSTAR)	Massachusetts Gen. Hospital Boston, Massachusetts	186,544	Sept. 1
Technology and Computer Science Applications	A Medical Information System Design Methodology	Washington University St. Louis, Missouri	549,074	Sept. 30
Technology and Computer Science Applications	Assessment of Technology in Chronic Disease	Stanford University Stanford, California	243,932	Sept. 30
Technology and Computer Science Applications	A Medical Database Approach to Evaluate Technology	Duke University Durham, North Carolina	433,704	Sept. 30
Dissertation Research	Grants for Dissertation Research Support	Various Institutions	186,000	Sept. 30
			$ 5,292,212	
NCHSR Contract Continuations: UNOBLIGATED Awards Pending			510,000	
			5,802,212	

ADDITIONAL QUESTIONS FOR THE RECORD

Senator SCHMITT. If a reprograming were undertaken as an alternative, wouldn't the funds have to be funneled from OASH programs through the budget authority provided for the $40 million PHS termination supplement?

Mr. MAHONEY. That's correct.

Senator SCHMITT. You have legislative authority to make such transfers, if that were necessary?

Mr. MAHONEY. Yes, sir.

Senator SCHMITT. We may have some additional questions for the record, folks.

We will move quickly on this. The main thing I want to do is determine that we in fact can get a supplemental through and what the consequences of that, of course, are. And I should have that answer within a few days, and we should be able to move one way or the other.

Dr. BRANDT. We are very grateful for the promptness of the hearing and your consideration of this.

Senator SCHMITT. Of course, we don't have an actual bill before us. The House has still yet to act. It's our understanding the full committee markup will be Thursday.

There does not seem to be any disagreement that if reprograming becomes necessary or feasible, or both, that we can do that and do that expeditiously. I have talked to Chairman Natcher, OMB Director Stockman, and members of this subcommittee, and I don't think there will be a problem there, if that turns out to be what we have to do. At least there won't be a problem over here. I realize it will cause you significant problems.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

THIRD PARTY RESOURCES

Question: How much money is involved from each source?

Answer: The breakout of the 1981 reimbursable projections is as follows:

Source of Third Party Funds	1981 Reimbursable Projection
Department of Defense	$38,900,000
State Programs	3,300,000
Community Programs	1,600,000
Other Programs	9,300,000
Renal Dialysis	1,600,000
Total	$54,700,000

FUTURE COSTS

Question: Would that "FAT" be the $1.1 million you attribute to rescissions and the $1.5 million you would like to tap from the Buildings and Facilities Account, but cannot because of the ceiling on operations?

Answer: No, the $1.1 million and $1.5 million are true funding necessities required in order to continue operating the PHS Hospitals and Clinics in fiscal year 1981. The $1.1 million was as a result of P.L. 97-12 which provided the hospital and clinic system a net total of $37,903,000 for closure costs as opposed to the $39 million which was required. The $1.5 million was originally Buildings and Facilities funds which were going to be reprogrammed into financial operations for the Hospitals and Clinics. However, P.L. 97-12 placed a funding limitation of $128.4 million on hospital operations, thereby precluding the Administration from executing the planned reprogramming into this account.

FURLOUGHS

Question: What is your schedule for furloughing the Public Health Service hospital staff?

Answer: If the $16.8 million supplemental is not granted, the following schedule of activities would take place in order to stay within available funds.

July 15 - Notice will be issued to full-time permanent/part-time permanent staff of intention to furlough.
- Cease purchasing supplies for the system.

Aug 1	- Cease inpatient admissions. - Terminate temporary staff.
Aug 15	- Furlough part-time permanent staff. - Discharge or transfer remaining inpatients.
Aug 22-Sept 9	- Furlough all civilian full-time permanent staff except 95 employees (for maintenance and security), PHS Commissioned Corps, and approximately 155 employees needed to stay on during interim furlough period (security guards, medical records, general services, telephone, and personnel staff). - Cease outpatient activities.
Oct 1	- Recall all furloughed staff for RIF process.
Oct 31	- RIFs effective for all except 95 employees for maintenance and security. PHS Commissioned Officers transferred.

Question: When will you begin the furloughs?

Answer: We would begin to furlough the part-time permanent staff on August 15.

Question: How many furloughed initially? How many later?

Answer: Approximately 274 part-time employees will be furloughed on or about August 15, 1981; and 3,754 full-time permanent employees will be furloughed between August 22 and September 9, 1981.

Question: Have furlough notices gone out to staff members?

Answer: On July 15 a 30-day advance general notice was issued to permanent and temporary employees informing them that a furlough may be forthcoming due to a shortage of funds.

Question: What will be done with the members of the Commissioned Corps and how many are involved?

Answer: There is no provision in the law for the furloughing of commissioned personnel; therefore, to the extent possible, services will be maintained by using commissioned personnel. Approximately 1,074 commissioned officers are involved.

STATUS OF HOSPITALS AND CLINICS

Question: If you furlough 4,500 - 5,000 staff members, how will the hospitals operate?

Answer: If it becomes necessary to furlough 4,500 - 5,000 staff members the hospitals will have to cease their operations.

Question: What about in and outpatient care -- what will be available?

Answer: All inpatient and outpatient care will be discontinued in the hospitals and clinics.

Question: Until when will the hospitals be open under your plans?

Answer: Inpatient services will be provided until approximately August 14. Outpatient services will be provided to beneficiaries approximately through September 1, 1981.

Question: What sorts of staff members will be on duty -- what will they do?

Answer: Members of the Public Health Service Commissioned Corps and civilian employees needed for security guards, medical records, general services, telephone, and personnel staff will remain on duty. Their function will be to begin working on the closedown procedures for the Public Health Service facilities.

Question: Do you plan to call the 4,500 - 5,000 staff back to work on October 1 and then fire them by October 31?

Answer: On October 1, 1981, all staff members furloughed will be recalled for reduction in force procedures; and on October 31 a reduction in force will become effective for all staff except 95 employees for maintenance and security. Public Health Service Commissioned Officers will be transferred.

GENERAL ACCOUNTING OFFICE REPORT ON PHS HOSPITALS

Question: How much money do you estimate has been wasted as a result of the poor procedures General Accounting Office alleges are involved?

Answer: We do not really know to what extent, if any, the procedures cited in the GAO report contributed to a loss in federal funds. I do believe, nevertheless that better procedures would have saved some funds.

Question: In view of the GAO report, how can Congress feel safe in giving you an additional $16.8 million for the program?

Answer: The issues cited in the GAO report and the need for this supplemental request are unrelated. The $16.8 million supplemental request is intended to support operations of the system for the remainder of F.Y. 1981 and particularly to preclude the necessity to furlough employees in the absence of adequate funding for the year. The financial needs of the program are in line with our phasedown operation and result from a loss in projected reimbursements and do not relate to the allegations contained in the GAO report.

Question: What are you doing to correct the deficiencies in verifying the eligibility of seamen coming to you for care?

Answer: The PHS hospitals have instituted a number of procedures to improve the management of admissions. These actions include the implementation of a policy of strict enforcement of established procedures for eligibility screening, training for employees in eligibility determination, and the installation of a computerized patient registration and eligibility verification function as part of the Public Health Automated Medical Information System (PHAMIS). The program also reviewed staff scheduling and performance in five hospitals as part of a new program to improve performance in the admissions departments.

Question: What action is being taken to ensure that practical means exist to verify the accuracy of documented evidence of seamen eligibility based on the current eligibility criteria?

Answer: We have implemented a policy of strict enforcement of established procedures for eligibility screening, training for employees in eligibility determination, and the installation of a computerized patient registration and eligibility verification function as part of the Public Health Automated Medical Information System (PHAMIS). The program also reviewed staff scheduling and performance in five hospitals as part of a new program to improve performance in the admissions departments.

Question: GAO also found that the hospitals were providing care to community residents who were not entitled to free care, but were expected to reimburse the hospitals based on their ability to pay. Contrary to established procedures, the hospitals were not verifying patients ability to pay, were not billing many patients who said they could pay, and were lenient in following up on delinquent accounts. What efforts are being made to correct these deficiencies?

Answer: We are pursuing a more vigorous reimbursement collection policy.

HEALTH SYSTEMS AGENCIES APPROVALS

Question: Do your closure plans require approval of local health systems agencies before you may proceed?

Answer: The Department has not required formal health systems agency review in the guidance for plan submission. The Administration's proposal was for repeal of Section 818, P.L. 93-155 which required health systems agency review and approval.

Question: Do you have such approval in all areas involved?

Answer: The Department has not required formal health systems agency review in the guidance for plan submission. The Administration's proposal was for repeal of Section 818, P.L. 93-155 which required health systems agency review and approval.

IMPOUNDMENT

Question: Do you plan to impound any of the 1981 money Congress provided for the Public Health Service Hospitals and Clinics?

Answer: No. We do not plan to impound any of the 1981 money Congress provided for the PHS hospitals and clinics.

Question: Do you plan to send up a request for any rescission or deferral of these funds?

Answer: We do not plan to request a rescission or deferral of these funds.

RECONCILIATION

Question: I know the House and Senate Reconciliation bills deal with the Public Health Service Hospitals, but still are somewhat different. Please explain the competing versions and tell us how much they will cost.

Answer: The House and Senate Reconciliation bills recommend closure of the Public Health Service Hospital and Clinic System in October 1981 unless the Secretary agrees, after a feasiblity study, to keep the facilities open as Federal Hospitals up to -- March 31, 1982 in the Senate bill and September 30, 1982 in the House bill. The House version extends Merchant Seamen entitlement through FY 1982. The Senate version terminates entitlement on September 30, 1981.

While the hospital and clinic system's closure agreement is based on the assumption that the community will take over the facilities where possible, it is not possible, at this time, to project an acceptable cost for conversion since specific detailed plans by all interested parties have not been approved.

Question: What is the status of the various community efforts to put the Public Health Service Hospitals under nonfederal sponsorship?

Answer: The status of converting the hospitals to the communities' sponsorship is as follows:

Boston: THe Allston Brighton Community Development Corporation (ABCDC) has submitted a letter of intent to acquire the Boston facility. The ABCDC's intent is not to operate a hospital but to act as a landlord for a number of tenant organizations, together with the establishment of a 75-unit housing complex. The health-social service components will include a senior citizens' multi-service center, an inpatient adolescent psychiatric unit, a community mental health center, an alcohol detoxification unit, and an alcoholic rehabilitation program. The letter of intent indicates that funds will be requested to subsidize the conversion for the health component of the program, but other funds will be sought for the social service and housing uses. No specific budget estimates have been given.

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Seattle: A public authority will be established with support from the city and the State. The plan is to operate as a community hospital. Most of the current employees will be retained and there will be a contract with the medical group comprised of the current medical staff. The Federal costs would be $48.9 million, of which $39.7 million is for renovation.

San Francisco: Under terms of the deed by which the Public Health Service initially acquired the facility, ownership reverts to the Army should PHS terminate operations. We have been informed by the Defense Department that the Army intends to exercise that option, but not to operate the facility as a general hospital. Rather, some services, largely administrative, but also including dental services, will be moved from the Letterman Army Hospital to the PHS facility. A request has also been received from the State of California, Office of the Governor, and the California Rural Indian Health Board for the Department to transfer ownership of the facility to the Indian Health Service. We have taken the position that Indians constitute a negligible portion of the patient workload, less than 5 percent, and that this does not justify operation of an Indian Health Service facility. However, we have indicated a willingness to consider a proposal from the State or the tribal organization for them to assume total operation of the facility using funds already available to them for other purposes from the Indian Health Service.

Staten Island: In terms of the medical necessity to the community, this hospital is the one which is most essential for continued operation as a community facility. St. Vincent's Hospital, the closest neighboring hospital on Staten Island, has submitted a letter of intent for its willingness to operate the facility as a community hospital. St. Vincent's plans to establish a separate board with representation from the community as well as from the other two voluntary hospitals on the Island. The Archdiocese and the Sisters of Charity have agreed to support this proposal. No formal budget proposal has been discussed but I anticipate a request for a operating Federal subsidy of about $2.6 million with some facility renovation also to be requested. That, however, is currently the subject of an ongoing architectural study and the number will not be available until close to August 15.

Question: We hear that the various communities or organizations may request millions of dollars from the Federal Government to facilitate this local sponsorship. What is going on? How much money might be in the cards?

Answer: While we do not know the full potential to be requested by the communities, at the present time we have received $82.1 million in requests from four communities; $54.7 million for facilities, $25.7 million for operations, and $1.7 million for research and training.

OBLIGATIONS IN OASH

Question: It appears that you have some $95 million still available from the $181.6 million available to the Office of the Assistant Secretary for Health in fiscal year 1981. That's a 53 percent availability with only two and a half months left in the fiscal year.

- In view of this, why don't you simply ask for a reprogramming of available OASH funds to secure the $16.8 million you claim you need.

- 56 percent is for overhead costs, is it not? Why can't some of this be reprogrammed?

- $35.4 million is for program continuations. Are you saying that you can't -- or won't -- trim down continuations a bit to reprogram money to PHS hospitals.

Answer: Although reprogramming from unobligated balances was one of the options considered, ultimately we decided to seek a supplemental rather than a reprogramming. The

$95 million that is unobligated is not as readily available for reprogamming as it might seem based on the total amount appropriated and the lateness of the fiscal year. The relatively large balance is due primarily to the inclusion of funds for fourth quarter operation and closure of the PHS Hospital system in the OASH account and the award cycle for continuation grants.

With regard to the $56.6 million unobligated in operating funds, $40 million is required for PHS termination expenses which in 1981 will support the 4th quarter operation and closure of PHS hospitals and Bureau of Medical Services administrative expenses. The remaining $16.6 million is required for the payment of salaries and benefits of OASH employees and other mandatory costs such as rental payments to GSA; postage, telephone, and utilities bills; and other ongoing operating expenses incurred in the activities of OASH. Further reductions to OASH direct operations or program support activities are not possible this late in the fiscal year.

We do not believe that the funds available as of July 20 for grant and contract continuations is appropriate for reprogrammining because:

- These funds are to support the continuation of existing projects and to fulfill a commitment to our grantees to maintain these efforts to their completion.
- Termination of these programs would mean losing the investments made in these programs in prior years. Both the adolescent health and the smoking and health program have been operational only one or two years and HMO grantees would be entering their final developmental phase after completing their planning process.
- Finally, the smoking and health and adolescent health grantees would be phased out before alternative funding became available through the Block Grant mechanism in 1982.

For these reasons I do not believe it is feasible to reprogram the $16.8 million from OASH unobligated balances.

NOTIFICATION OF FURLOUGH

Question: To what extent does your notification of plans to furlough Public Health Service hospital staff fall within the requirements of the Administrative Procedure Act?

Answer: Notification of furlough to employees falls within the provision of laws and regulations pertaining to the Civil Service, for example, 5 USC 7511 - 7514 and 5 CFR Part 752. In cases involving a negotiated agreement with an organization representing employees the provisions of 5 USC Chapter 71 apply. However, furlough plans are not subject to the Administrative Procedures Act which pertain generally to rule making and adjudications.

Question: The Federal Medical Care Recovery Act of 1963 establishes the Government's right to recover costs of medical care provided to persons as a result of negligence of third parties (tort liability circumstances). GAO's examination of four PHS hospitals showed that the hospitals generally were not attempting to identify patients who were treated in PHS facilities or by private health providers for injuries incurred under tort conditions. Cases which were identified and referred to the HHS Office of General Counsel for collection resulted in little action in pursuing collections. The statute of limitations had expired on many of these cases, closing out PHS opportunities to recover costs from liable third parties. What attempts are being made to correct this situation?

Answer: At the time the GAO submitted its recommendations concerning recovery from liable third parties, the Department did not concur with the GAO finding. The Bureau of Medical Services began the development of new procedures to improve the identification and reporting of potential third party claims to the Office of General Counsel.

Question: GAO findings reveal that if PHS had required eligibility data for all claimants seeking care as seamen and reviewed the data, it would have precluded some ineligibles from receiving care. What action is being taken to train admissions personnel to correct this management weakness?

Answer: The PHS Hospitals have initiated a program of on-the-job training in existing administrative procedures to preclude the admission of ineligible persons. In addition, an automated admissions and eligibility determination module to the Public Health Automated Medical Information System (PHAMIS) has been implemented in three hospitals with two additional hospitals scheduled for F.Y. 1981. The remaining hospitals were scheduled for F.Y. 1982.

LACK OF MANAGEMENT CONTROL OVER CONTRACT HEALTH CARE PROGRAM

Question: PHS provides medical, dental, and pharmaceutical services to eligible seamen, members of the Coast Guard, National Oceanographic and Atmospheric Administration Personnel, and PHS-Commissioned Corps Officers. When its hospitals or clinics are unavailable or cannot provide certain health care services, PHS contracts with private providers to render services to eligible recipients. Contract Care Program costs have escalated from about $3.2 million in fiscal year 1970 to an estimated $32.5 million for fiscal year 1981.

GAO found that PHS has little control over the volume cost, or quality of services provided under the Contract Care Program. What actions are PHS hospitals taking to ensure the use of uniform criteria for determining:

-- Locations and numbers of beneficiaries which justified a contract provider.

-- Numbers of contract providers needed, and

-- Procedures for selecting contract providers?

Answer: In conjunction with contingency planning for the discontinuation of PHS hospital and clinic operations, surveys have been conducted to determine the numbers and locations of PHS beneficiaries who would retain entitlement to care following closure of the system and disentitlement of merchant seamen. Based on these demographic data and workload experience in the current system, a population has been identified for whom contract patient care services would be required. These data have been adjusted to determine the full-time equivalent providers with whom contracts would be required. In addition, a contract patient care manual which details procedures for operating the program is in preparation.

OTHER QUESTIONS

Question: What methodologies could have been employed to better anticipate the funding requirements which have occurred since the submission of the initial closure plan? What are you doing to improve your estimating?

Answer: With the closure of the system originally planned for early fiscal year 1982, it was extremely difficult to assess the impact the phasedown would have on our reimbursable income for fiscal year 1981, particularly as we got closer to the October 1, 1981 date. In addition, the actions by the Federal Court system on the Contract Patient Care Program and by P.L. 97-12 could not have been realistically anticipated.

At the present time, we are monitoring our expenditures and reimbursements as closely as possible to assure the validity of our assumptions.

Question: What alternatives and other potential sources of funding within the Department were considered during your review of this supplemental request?

Answer: We examined the possibility of reprogramming. At this level of money, should we have to reprogram funds, we would have to cut off continuation grants to grantees in the States in the area of health services research, health statistics, health care technology; we would not be able to continue the health maintenance organization commitments; and we would begin to reduce continuation grants, not new ones, continuation grants, in adolescent pregnancy, smoking and health and other programs.

To take the money from a reprogramming would mean that we would have to do away with commitments already made to grantees.

Question: It is noted that a component of the $16,800,000 request includes something called "other services" at $4,118,000. Can you explain what this amount would be used for?

Answer: The additional $4.1 million required in "otner services", will be used to purchase the necessary medical consultant services, specialized diagnostic, laboratory and therapeutic services, and the minimum amount of structural maintenance and repairs needed to keep the facilities safe and functional.

Question: Please explain the status of employees of the hospital, civil servants, wage board employees and others, the timetable for their separation or furlough, fringe benefit payments, and severance pay required, etc..

Answer: If the $16.8 million supplemental is not approved, approximately 497 temporary employees will be terminated on August 1; 274 part-time permanent employees will be furloughed on August 15; and 3,574 civilian full-time permanent employees will be furloughed between August 22 and September 9. During the interim furlough period, approximately 1,074 PHS Commissioned Corps and 155 employees will be retained for the closure process.

The benefits to furloughed employees are that life insurance will continue for the six weeks without cost to employee; health Benefits coverage will probably be extended for 31 days from the last day in the pay period in which the furlough commences (The Office of the Secretary is verifying this with the U.S. Office of Personnel Management); annual leave and severance pay will not be granted; sick leave may be granted if otherwise justifiable if the money is available (Initial Health Service Administration determination is that there will be no sick leave paid); and unemployment compensation will be determined by the local unemployment office.

Question: What provisions have been established to enable the orderly phasedown of care for inpatients and outpatients at these hospitals?

Answer: The Public Health Service has developed a detailed plan for the orderly phasedown of operations in the PHS hospitals and clinics. This plan has been expressed in elements of work projects which are being tracked by category of task, location, and time of expected completion. Policy guidance is being provided by the Bureau of Medical Services and implementation of the plan has been delegated to task forces at the local facility. Oversight of the entire closure operation is being maintained by a task force consisting of representatives of the Health Services Administration, Public Health Service, and Office of the Secretary.

Question: Will contract care continue?

Answer: Yes, contract patient care will continue for primary beneficiaries other than American Seamen. Primary beneficiaries who remain, after Seamen disentitlement, include PHS Commissioned Officers, active duty members of the Coast Guard, and commissioned officers of the National Oceanic and Atmospheric Administration. Also, in fiscal year 1982, medically indigent persons who have been receiving care in PHS facilities will be eligible for contract care at Federal expense, while alternative arrangements are being made to gain their access into a community health care setting.

Question: What plans have been put in place to enable the potential transition of these hospitals to eligible communities and what effect, if any, does this supplemental request have on aiding them in their efforts?

Answer: The Secretary has consulted with the Governors of the affected States to provide technical assistance from the Department of Health and Human Services.

This supplemental request is necessary so that community takeover plans are not disrupted by a premature closure of the PHS hospitals and clinics.

SUBCOMMITTEE RECESS

Senator SCHMITT. With that, I will adjourn the hearing and be back in touch with you.

Dr. BRANDT. Thank you, sir.

[Whereupon, at 4 p.m., Monday, July 20, the subcommittee was recessed, to reconvene at the call of the Chair.]

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